

S. 8-43
5-17-39
PI X37823

FILED OCT 8 1945

Registration District No. 122

Primary Registration District No. 4201

Registrar's No. 17

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Republic
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Name 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Republic 0
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME DAVID NEWTON JENKINS

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17 year 1945 hour 7:07 AM minute _____ M.

21. I hereby certify that I attended the deceased from July 24 1944 to Sept 17 1945

that I last saw him alive on Sept 18 1945 and that death occurred on the date and hour stated above.

Immediate cause of death _____

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife Josephine Jenkins 6. (c) Age of husband or wife if alive deceased years _____

7. Birth date of deceased July 7 1862
(Month) (Day) (Year)

8. AGE: Years 83 Months 2 Days 11 If less than one day hr. _____ min. _____

9. Birthplace Ray County Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

MOTHER FATHER

12. Name John Jenkins

13. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Mary Boyers

15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mahel Allen

(b) Address Republic, Mo.

17. (a) Burial (b) Date thereof 9-19-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director V. L. Burman

(b) Address Republic Mo.

19. (a) Sept. 19-1945 (b) Glaume Brittain
(Date received local registrar) (Registrar's signature)

Due to Myocarditis

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 932

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of work) (e) _____ (Specify place of injury)

23. Signature F. B. M. Allen (M. V. or other) _____

Address Republic Mo. Date signed 9-19-45

RECEIVED

Greene County Health Office,

County File Number

45-10-71

Date Filed

10-6-45

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

R. E. Thurman

Registered Apprentice No.....

working under my personal supervision.

Signed *R. E. Thurman*

Licensed Embalmer No. 508

P. O. Address *Republic Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. *oct*

Registration District No. *122*

Primary Registration District No. *4201*

Registrar's No. *17*

1. PLACE OF DEATH:
(a) County *Green*
(b) City or town *Republic*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME *David N. Jackson*
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *m* 5. Color or race *w* 6. (a) Single, widowed, married, divorced *Widower*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased *Josephine July 7*
(Month) (Day) (Year)

8. AGE: Years *83* Months *2* Days *ms* If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) *(Florence Britain)*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Months _____ Days _____
year *1948* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

30573