

S. No. 2
M-5-43
V. 5-17-39
I X36871

FILED JUN 12 1946
Registration District No. **42**

Primary Registration District No. **1000**

1. PLACE OF DEATH:
 (a) County **Buchanan**
 (b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Mercy Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **One week**
(Specify whether years, months or days)
 In this community **10 years**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Buchanan**
 (c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1204 No. 2nd St.**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **James E. Jennings**
 3. (b) If veteran **World War #1** name war
 3. (c) Social Security No. **none**
 4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Viola May Jennings**
 6. (c) Age of husband or wife if alive **46** years
 7. Birth date of deceased **December 29 1895**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **June** day **6** year **1946** hour **5** minute **30** A.M.
 21. I hereby certify that I attended the deceased from **May 27**, 1946, to **June 6**, 1946;
 that I last saw her alive on **June 6** and that death occurred on the date and hour stated above.
 Immediate cause of death **Cerebral Hemorrhage** Duration _____

8. AGE:	Years	Months	Days	If less than one day
	50	5	7	hr. min.

Due to **Latent vessel**
 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.

9. Birthplace **Leon Iowa**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Plumber**
 11. Industry or business **Plumbing for self**
 12. Name **Wm. Henry Jennings**
 13. Birthplace **Leon Iowa**
(City, town, or county) (State or foreign country)
 14. Maiden name **Rhoda Adain**
 15. Birthplace **Leon Iowa**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. James E. Jennings**
 (b) Address **1204 No. 2nd St.**
 17. (a) **Removal** (b) Date thereof **June 6/46**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Stanberry Mo.**
 18. (a) Signature of funeral director **Horton B. Gale, Bowman**
 (b) Address **St. Joseph, Mo.**
 19. (a) **June 8-1946** (b) **H. W. Nishel**
(Date received local registrar) (Registrar's signature)

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 **2**
 23. Signature **J. E. Smith** (M. D. or other) **MD**
 Address **203 Kirkpatrick Bldg** Date signed **6-6-46**

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

184

JUN 7 1948

OCT 11 1948

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 ~~_____~~

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed *Raymond H. Hershend*

Licensed Embalmer No. *4413*

P. O. Address *319 So 10th St Joseph*

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.