

**1. PLACE OF DEATH:**  
 (a) County Vernon  
 (b) City or town Arwada - not rural (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: State Hospital No 3. 2  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 7 days (Specify whether)  
 In this community 7 days years, months or days

**3. (a) PRINT FULL NAME** Charles Jennings  
 3. (b) If veteran, name war 1  
 3. (c) Social Security No. None

4. Sex M Color or race W  
 6. (a) Single, widowed, married, divorced D. 2  
 6. (b) Name of husband or wife ?  
 6. (c) Age of husband or wife if alive ? years  
 7. Birth date of deceased 2 5 1888  
 (Month) (Day) (Year)

**8. AGE:**  
 Years 63 Months 5 Days 24  
 If less than one day — hr. — min.

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

10. Usual occupation Farming

11. Industry or business —

**MOTHER FATHER**  
 12. Name John Jennings  
 13. Birthplace Missouri  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Margaret Bradley  
 15. Birthplace Missouri  
 (City, town, or county) (State or foreign country)

16. (a) Informant Records

(b) Address State Hospital No 3

17. (a) Removal (b) Date thereof 7-29-46  
 (Funeral, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nuclear, Mo

18. (a) Signature of funeral director Cochran, Fern Home

(b) Address Nevada Mo

19. (a) 7-30-46 (b) Walter J. Jarey  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County St Louis  
 (c) City or town Calhoun Mo (Rural)  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 7 day 29  
 year 1946 hour 4 minute 10 P.M.

21. I hereby certify that I attended the deceased from 7-22-1946 to 7-29-1946  
 that I last saw him alive on 7-29-1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death Moment of exhaustion  
 Due to Senile Dementia  
 Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
 Of operations None  
 Of autopsy guc

Duration \_\_\_\_\_  
 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) no  
 (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? \_\_\_\_\_

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

23. Signature J.P. Bunch (M. D. —)  
 Address State Hospital Arwada Mo Date signed 7-29-46

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

RECEIVED  
DATE FILED 7-46-808  
8-8-46

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

Signed Mark E. Eshinger  
Licensed Embalmer No. 2686  
P. O. Address Nevada, 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.