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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

11040

FILED APR 14 1947 STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 2653

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Saint Louis Maternity Hospital
(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 _____
(c) City or town Webster Groves
(If outside city or town limits, write "RURAL")
(d) Street No. 217 Bompert Avenue
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME INFANT JENKERSON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race white 6. (a) Single, widowed, married, divorced 6

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

7. Birth date of deceased April 6, 1947
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 5 hr. 35 min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Warren H. Jenkerson
13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Virginia E. Blackburn
(City, town, or county) (State or foreign country)
15. Birthplace Cambria Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Saint Louis Maternity

(b) Address 630 S. Kingshighway

17. (a) Burial (b) Date thereof 4/17/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director J. F. Bredek

(b) Address 1027 Hawthorn Ave.

19. (a) APR 7 1947 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7
year 1947 hour 5:30 AM minute _____ M.

21. I hereby certify that I attended the deceased from in
_____ 19____ to Apr 7 1947
that I last saw him alive on Apr 7 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Duration _____

Due to Pneumonia
33 weeks gestation

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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 J. P. Dr. Mackley (M. D. or other) M.D.

Address 4932 Maryland Date signed 07/2/47

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

0
7
9

96
7
NK.4
1

159

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

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.....

Not Embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.