S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11043 2522

FILED MAR 24 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

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:
McMillan 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 Alabama (b) County Barbour

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

(d) Street No. N.B.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Kate Bebee Jennings

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Comer Jennings

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased October (Month) 14 (Day) 1903 (Year)

8. AGE: Years 43 Months 4 Days 26 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Clarence Roberts
13. Birthplace Eufaula (City, town, or county) Alabama (State or foreign country)

MOTHER
14. Maiden name Georgia Archibald
15. Birthplace Oxford (City, town, or county) Alabama (State or foreign country)

16. (a) Informant James L. Miller
(b) Address 8014 Watkins Street.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/10/47 (Month) (Day) (Year)
(c) Place: burial or cremation Montgomery Alabama

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) (Date received local registrar) (b) J. F. Bredell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10 year 1947 hour 3 minute 3:00 P.M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage of Burst Aneurism Coarctation of Aorta which he jumped from a window of Room #404 Mc Millan Hospital where he was a patient around 3:00 P.M. March 9, 1947 suicide

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)
While suffering a temporary

Major findings
Of operations Aberration

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) Suicide

(b) Date of occurrence March 9, 1947

(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? McMillan Hospital (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed 3/10/47

(Licensed Embalmer's Statement on Reverse Side)

2522

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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 Henry M. Brammer

Licensed Embalmer No. 4200

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.