

**FILED JUN 9, 1947**

Registration District No. **28**

Primary Registration District No. **2000**

Registrar's No. **448**

**1. PLACE OF DEATH:**

(a) County Green

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

(c) Name of hospital or institution: St. Johns Hospital 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 weeks  
(Specify whether years, months or days)

In this community 5 weeks

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Stone 104

(c) City or town Galena, Rt #1  
(If outside city or town limits, write "RURAL")

(d) Street No. 1 1/2 mi. W. of Galena  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** James William JENNINGS

(b) If veteran, name war \_\_\_\_\_

(c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month May day 27<sup>th</sup> year 1947 hour 2 minute 35 P.M.

**21. I hereby certify that I attended the deceased from** April 23, 1947 to May 27, 1947  
that I last saw him alive on May 27, 1947  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Josephine JENNINGS

6. (c) Age of husband or wife if alive dead years \_\_\_\_\_

7. Birth date of deceased April 22 1871  
(Month) (Day) (Year)

Immediate cause of death Arteriosclerotic heart disease Duration 6 yrs.

Due to Arteriosclerosis 15 yrs.

**8. AGE:**

Years	Months	Days	If less than one day
<u>76</u>	<u>1</u>	<u>5</u>	<u>-</u> hr. <u>-</u> min.

Due to \_\_\_\_\_

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

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

10. Usual occupation Farming

11. Industry or business Farm

Major findings: 978

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

**MOTHER FATHER**

12. Name Zackus D. Jennings

13. Birthplace Tenn. 1  
(City, town, or county) (State or foreign country)

14. Maiden name Louviea Haggard

15. Birthplace Tenn. 1  
(City, town, or county) (State or foreign country)

**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? \_\_\_\_\_

16. (a) Informant Mrs. Seab Fultz

(b) Address Rt #1 Galena, Mo.

17. (a) Burial (b) Date thereof 5-29-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galena Cemetery

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

(c) Means of injury \_\_\_\_\_

23. Signature J. D. Filley (M. D. or other) \_\_\_\_\_  
Address 205 St. Louis St. Spfld, Mo. Date signed May 27 47

18. (a) Signature of funeral director: Koon Funeral Home

(b) Address Cassville, Mo.

19. (a) 5-27-47 (b) W. H. Handley, Jr.  
(Date received local registrar) (Registrar's signature)

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

---

---

**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.....

.....  
working under my personal supervision.

Registered Apprentice No.....

Signed.....

*J. C. Canada*

Licensed Embalmer No.....

*4196*

P. O. Address.....

*Cassville, 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.**