No. 2
—8-43
5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23386

Registration District No. 33 Primary Registration District No. 4044 Registrar's No. 9

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Sturgeon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community all of life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone 10
(c) City or town Sturgeon 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Annie Dillard Jennings
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex Female
5. Color or race Wh
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec. (Month) 10 (Day) 1872 (Year)
8. AGE: Years 75 Months 7 Days 5 If less than one day hr. min.
9. Birthplace Boone Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Housf.
11. Industry or business
MOTHER FATHER
12. Name Jackson Winn
13. Birthplace Mo. (City, town, or county) (State or foreign country)
14. Maiden name Martha Sims
15. Birthplace Mo. (City, town, or county) (State or foreign country)
16. (a) Informant Virgil L. Jennings
(b) Address Sturgeon, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Union Cem.
18. (a) Signature of funeral director Barnes & Booth
(b) Address Sturgeon Mo.
19. (a) July 17, 1947 (Date received local registrar) (b) Thelma J. Eatinger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 15 year 47 hour 5 minute 01 P M.
21. I hereby certify that I attended the deceased from 6/1/47 to 7/15/47, 19..; that I last saw he alive on 6/14/47, 19..; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	
Due to Cardio-respiratory failure	
Due to	
Other conditions Cancer Jan. 47. (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Autopsy	

Ellis Fischel Hosp. Columbia Mo.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)
(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 O. L. Barnes Jr MD (M. D. or other)
Address Sturgeon Mo Date signed 7/16/47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 7-23-47

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.....A. E. Booth.....

Licensed Embalmer No.....4087.....

P. O. Address.....Sturgeon, 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.

No. 2B
M—3-45
1 X43880

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. Arg

Registration District No. 33 Primary Registration District No. 4047 Registrar's No. 9

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution:
(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 (b) County

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

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

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

3. (a) PRINT FULL NAME Annie D. Jennings

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec. 10 1872
(Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 25 year 1947 hour minute 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

Due to

Due to

53

Other conditions on face Left Lower side
(Include pregnancy within 3 months of death)
over Maxillary Sinus - removed

Major findings:
Of operations at Ellis Fischer Hospital
Columbia MO - Type unknown
Of autopsy to me

Duration

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)

(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 F Carroll Jr (M. D. or other)
Address Sturgeon MO Date signed 24 July 47

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