

S. No. 2
M-2-43
17-39
255897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28434

State File No. _____

FILED SEP 2 1947

Registration District No. 21818

Primary Registration District No. 5821

Registrar's No. 230

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Mathias 131-1110
(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 Mo (b) County New Madrid
(c) City or town Mathias 131-1110
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) Rural
(e) Citizen of foreign country? No (Specify No)
If yes, name country _____

3. (a) PRINT FULL NAME

Jordan Jenkin

3. (b) If veteran, name _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) ~~Single~~ married ~~divorced~~
6. (b) Name of husband or wife Jordan Jenkin 6. (c) Age of husband or wife if alive 33 years
Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 31 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business Home wife

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name Jordan Jenkin
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant J. E. Jenkins
(b) Address Mathias 21-1110

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

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

19. (a) 8-19-47 (b) Helene Lovelace Jones
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 19
year 1947 hour 12 Midnight M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him alive on 8-18, _____ 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Child birth
Due to Placenta Praevia

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

Major findings: _____
Of operations 146
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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature G. N. Wilson (M. D. certificate) _____
Address Mathias 1110 Date signed 8-19-47

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2,

District File Number 847-1149

Date Filed 8-28-47

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.....

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.

1-1/47
5-17-39

Dr. Wilson Lill 2038
Registration District No. 2038

Primary Registration District No. 5821

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

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Rural
(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 1 Year
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

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

(d) Street No. 12 miles So. of Sikeston
(If rural, give location)
on Hiway 61 no _____ (Yes or No)

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

3. (a) PRINT FULL NAME Geraldine Jenkins

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 19 1947
year 1947 hour 12 minute 45 a. M.

21. I hereby certify that I attended the deceased from 8-18-47 1947 to _____ 19_____
that I last saw him _____ alive on _____ 19_____
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced _____ M

6. (b) Name of husband or wife James E. Jenkins 6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased Dec 31 1916
(Month) (Day) (Year)

Immediate cause of death Child birth
Placenta Previa

Due to _____

Due to _____

8. AGE: Years 30 Months 7 Days 18 If less than one day _____ hr _____ min

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

10. Usual occupation Housewife

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

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause of which death should be charged statistically.

11. Industry or business _____

MOTHER FATHER { 12. Name Frank Fivecoats

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

14. Maiden name Unknown

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

16. (a) Informant James Jenkins
(b) Address Matthews, Mo. R.F.D. #1

17. (a) Burial (b) Date thereof 8/22/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jamestown Ark.

18. (a) Signature of funeral director H.W. Albritton
(b) Address Sikeston, Mo.

19. (a) 8-19-47 (b) Helen Louise Jones
(Date received local registrar) (Registrar's signature)

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? _____ (Specify type of place) (e) Means of injury _____

23. Signature H. H. Wilson (M. D.)
Address Filsham, Mo. Date signed 8-18-47

5-28434

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 John G. Miller

Licensed Embalmer No. 2941

P. O. Address Superior, 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.