S. No. 2
M—1/47
. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 6 1947

Registration District No. 128

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

State File No. 30925

Registrar's No. 847

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution: O'Reilly VA Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 62 Days (Specify whether
In this community 62 Days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ~~St. Louis~~ 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 4553 Aldine 9
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Emmett A. Hennings

3. (b) If veteran, name war World War II

3. (c) Social Security No. Unk

4. Sex Male 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife —

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

7. Birth date of deceased January (Month) 28, (Day) 1920 (Year)

8. AGE:

Years	Months	Days	If less than one day
27	7	28	hr. min.

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

10. Usual occupation Waiter

11. Industry or business

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

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

16. (a) Informant Clinical Records
(b) Address O'Reilly VA Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-47 (Month) (Day) (Year)
(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Forman Schaeffer F.H.
(b) Address Springfield Mo.

19. (a) 9-26-47 (Date received local registrar) (b) W. E. Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 25
year 1947 hour 3 minute 18 P.M.

21. I hereby certify that I attended the deceased from July 24, 1947 to September 25, 1947; that I last saw him alive on September 25, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary, chronic far advanced.

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Same as Above.

Duration

PHYSICIAN

Underline the cause of 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? Paul L. Eisele (e) Means of injury

23. Signature PAUL L. EISELE (M. D. ~~XXXX~~)

Address O'Reilly VA Hospital Date signed 9-25-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

FEB 25 1948
JAN 9 1948
MAR 7 1950

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 Lewis D. Schaefer

Licensed Embalmer No. 3802

P. O. Address Springfield, 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.