

S. No. 2  
DM-5-43  
v. 5-17-39  
X36871

FILED JAN 20 1948

Registration District No. **344**

Primary Registration District No. **6162**

Registrar's No. **1**

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

1. PLACE OF DEATH: **Stone**

(a) County **Stone**

(b) City or town **REEDS SPRING MO**  
(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 **75 yrs** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** (b) County **Stone 104**

(c) City or town **REEDS SPRING**  
(If outside city or town limits write "RURAL")

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

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

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

3. (a) PRINT FULL NAME **FLORENCE ELIZABETH JENNINGS**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** / race **w**

5. Color or race **w**

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

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

7. Birth date of deceased **Mar 14 1871**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **30** year **1947** hour **4** minute **35** A.M.

21. I hereby certify that I attended the deceased from **Dec 23** 19**47** to **Dec 30** 19**47** that I last saw her alive on **Dec 29** 19**47** and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<b>76</b>	<b>9</b>	<b>16</b>	_____ hr. _____ min.

Immediate cause of death **Cerebral Hemorrhage**

Due to **Arteriosclerosis and angina pectoris**

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

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

Major findings: \_\_\_\_\_

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

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

9. Birthplace **Bren Forest Ark.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Prof.**

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? \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name **Henry Thomas**

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

14. Maiden name **ANMETA SURBER**

15. Birthplace **Mexico Mo.**  
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant **Wm. Thomas**

(b) Address **REEDS SPRING MO**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Jan 1-48**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Thomas Cemetery**

18. (a) Signature of funeral director **Everett Cheatham**

(b) Address **Salina Mo**

19. (a) **Jan 5 1948** (Date received local registrar) (b) **Juanita D. Stults** (Registrar's signature) **2/14**

23. Signature **L S Shumate** (M. D. or other) \_\_\_\_\_

Address **REEDS SPRING MO** Date signed **12/30/47**

RECEIVED

District Health Officer No. 6;

District File Number 148-91

Date Filed JAN 17 1948

*was registered as fourth  
p. 148-91*

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 Everett J. Cheatham

Licensed Embalmer No. 3870

P. O. Address Salena 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.