

1. PLACE OF DEATH:  
 (a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 mo. 4 days  
(Specify whether  
 In this community 70 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3828 Paseo  
(If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mamie Jennings  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. none

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Dec. day 28  
 year 1948 hour 7 minute 40 P. M.

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife Linton H. Jennings  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased April 18, 1867  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 24 1948 to Dec. 28 1948  
 that I last saw her alive on Dec. 28 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia and lung abscess  
 Duration \_\_\_\_\_

8. AGE: Years 81 Months 8 Days 10  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

9. Birthplace Keokuck, Iowa  
(City, town, or county) (State or foreign country)  
At Home

10. Usual occupation \_\_\_\_\_

Other conditions 107  
(Include pregnancy within 3 months of death)

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

Major findings: 107  
 Of operations \_\_\_\_\_

12. Name James P. Gleason  
 13. Birthplace Ireland  
(City, town, or county) (State or foreign country)

Of autopsy See above  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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

16. (a) Informant Harold J. Jennings  
 (b) Address 3828 Paseo

22. If death was due to external causes, fill in the following:

17. (a) Burial (b) Date thereof Dec. 31, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_

(c) Place: burial or cremation Mt. St. Mary's

(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? 0

18. (a) Signature of funeral director Wm. W. Hart  
 (b) Address 4316 Troost Ave.

Wm. W. Hart (Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

19. (a) 12-30-48 (Date received local registrar)  
Skaldine Holmes (Registrar's signature)

23. Signature Wm. W. Hart (M. D. or other) 12-29-48  
 Address Med. Dir. Gen'l Hosp. Date signed \_\_\_\_\_

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

MOTHER FATHER

*R. Pham*

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**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 *Thomas E. Link*  
Licensed Embalmer No. *3775*  
P. O. Address *N.C. 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.**