

FILED MAY 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16712

State File No.

BIRTH NO. _____ REG. DIST. NO. 239 PRIMARY REG. DIST. NO. 4326 Registrar's No. 22

1. PLACE OF DEATH a. COUNTY NEW MADRID		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY NEW MADRID	
b. CITY OR TOWN PARMA		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN PARMA	
d. FULL NAME OF HOSPITAL OR INSTITUTION NONE		d. STREET ADDRESS (If rural, give location) PARMA MO.	

3. NAME OF DECEASED (Type or Print) LEONA JENKINS			4. DATE OF DEATH MAY 2 1949		
a. (First)	b. (Middle)	c. (Last)	(Month)	(Day)	(Year)

5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MARCH 7, 1888	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months 1 Days 25	IF UNDER 1 HR. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) HARRISBURG ILLINOIS/	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME H. J. REED	13b. MOTHER'S MAIDEN NAME SARAH JANE SIMMONS	14. NAME OF HUSBAND OR WIFE OTT JENKINS
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Ott Jenkins	ADDRESS Parma, MO
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 Days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Hypertension		
	DUE TO (c) 		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			331A

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 4-15, 1949, to 5-2, 1949, that I last saw the deceased alive on 5-2, 1949, and that death occurred at 8:50 A.M. from the causes and on the date stated above.

23a. SIGNATURE H. Gilbert	(Degree or title) res.	23b. ADDRESS Parma, Mo.	23c. DATE SIGNED 5/3/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/4/49	24c. NAME OF CEMETERY OR CREMATORY Malden	24d. LOCATION (City, town, or county) (State) Malden MO
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DATE REC'D BY LOCAL REG. 5/3/49	REGISTRAR'S SIGNATURE H. R. Gilbert	FUNERAL DIRECTOR'S SIGNATURE Walter W. Nathan	ADDRESS Four Seaside Parma, Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Office No. 2,

District File Number 542-525

Date Filed 5-18-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed B. B. Bremlinger

Signed _____

Student Embalmer

Licensed Embalmer No. 4201

P. O. Address Wyster 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.