

FILED DEC 9 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 37088  
Registrar's No. 4875

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

008

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

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>	
c. LENGTH OF STAY (in this place) <b>1908</b>		d. STREET ADDRESS (If rural, give location) <b>4000 Wabash</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4000 WABASH AVENUE</b>			

3. NAME OF DECEASED (Type or Print) <b>Abram Jenkinson</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 17-1950</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JULY 1 1885</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months Days	IF UNDER 28 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PARTNER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LINEIN STORE</b>		11. BIRTHPLACE (State or foreign country) <b>IRELAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>ABRAM JENKINSON</b>		13b. MOTHER'S MAIDEN NAME <b>JANE McLAUGHLIN</b>		14. NAME OF HUSBAND OR WIFE <b>ALICE L. JENKINSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs ALICE L. JENKINSON</b> ADDRESS <b>4000 WABASH KANSAS CITY, MO.</b>	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congestive Heart Failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Pulmonary tuberculosis</b>			Years <b>002 1/2</b>
		DUE TO (c) <b>(Advanced - Bilateral)</b>			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Tuberculosis diagnosed April 1949</b>			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	

22. I hereby certify that I attended the deceased from June, 1949, to Nov. 16, 1950, that I last saw the deceased alive on Nov 12, 1950, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE <b>Joseph E. Walker</b> (Degree or title) <b>MD</b>		23b. ADDRESS <b>836 Professional Bldg</b>		23c. DATE SIGNED <b>11-17-50</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>Nov 20 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>	
DATE REC'D BY LOCAL REG. <b>11-20-50</b>		REGISTRAR'S SIGNATURE <b>Sheraldine Holmes</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>D.H. Newcomer</b> ADDRESS <b>1331 BRUSH CREEK KANSAS CITY, MO.</b>			

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed.....  
Student Embalmer

Signed..... *John C. Fraking*

Licensed Embalmer No. *4483*

P. O. Address *Kansas City, 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.