No. 300
10.48

FILED MAR 17 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8570

State File No. 890

BIRTH NO. 14704-51 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 0485

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (In this place): life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Research Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Independence
d. STREET ADDRESS (If rural, give location): 1002 N. Main X 1

3. NAME OF DECEASED (Type or Print): a. (First) Baby b. (Middle) c. (Last) Jennings

4. DATE OF DEATH (Month) (Day) (Year): 2-17-1951

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): —
8. DATE OF BIRTH: 2-16-1951
9. AGE (In years last birthday): 0 — If under 1 year: Months — Days — If under 24 hrs.: Hours 11 Min. 16

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Cleo M. Jennings
13b. MOTHER'S MAIDEN NAME: Nellie M. Clements
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS: Mrs Nellie Jennings

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature (2 wks) — INTERVAL BETWEEN ONSET AND DEATH: 12 hr.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

Twin

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-16-, 1951, *to* 2-17, 1951 *that I last saw the deceased alive on* 2-17, 1951, *and that death occurred at* 8:35 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Melvin Langhus (Degree or title) MD
23b. ADDRESS: No Kansas City Mo
23c. DATE SIGNED: 2-17-51

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: 2-17-51
24c. NAME OF CEMETERY OR CREMATORY: Research Hospital
24d. LOCATION (City, town, or county) (State): Kansas City Mo.

DATE REC'D BY LOCAL REG.: 2-27-51
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Research Hosp. K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.