

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19937

State File No.

BIRTH NO. _____ REG. DIST. NO. #128 PRIMARY REG. DIST. NO. 5465 Registrar's No. 587

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural, N. Campbell Twp</u> TOWN <u>Springfield R. #4</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield Rural, N. Campbell Twp</u>	
c. LENGTH OF STAY (In this place) <u>23 Da</u>		d. STREET ADDRESS (If rural, give location) <u>Route # 4</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Greene County Hosp</u>		0390	

3. NAME OF DECEASED (Type or Print) <u>John Jenson</u>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>July 4 1951</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>	11. BIRTHPLACE (State or foreign country) <u>9</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Hana H. Jenson</u>	13b. MOTHER'S MAIDEN NAME <u>Andrea Christenson</u>	14. NAME OF HUSBAND OR WIFE <u>Unknown</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Greene County Hospital Records, Springfield, Mo</u>	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer of Liver</u>		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>156 A</u>	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) m.	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 6-10-, 1957, to 7-4-, 1957, that I last saw the deceased alive on 7-3-, 1957, and that death occurred at 1 P m., from the causes and on the date stated above.

23a. SIGNATURE <u>W Kelly MD</u> (Degree or title)	23b. ADDRESS <u>Springfield Mo</u>	23c. DATE SIGNED <u>7-5-57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>July 5 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Rock Falls</u>	24d. LOCATION (City, town, or county) (State) <u>Rock Falls, Ill</u>
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DATE REC'D BY LOCAL REG. <u>7/5/51</u>	REGISTRAR'S SIGNATURE <u>W E Sandly MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Gorman-Scharpf Funeral Home</u>	ADDRESS <u>Springfield, Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0390

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.

Student
Student Embalmer

Signed

L. Deane Gorman

Licensed Embalmer No. 3177

P. O. Address Springfield, 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.