

FILED AUG 7 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24296
6750

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY 0				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 18 mos		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2259				
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				STREET ADDRESS (If rural, give location) 906 Biddle 0				
3. NAME OF DECEASED (Type or Print) a. (First) Jennie b. (Middle) _____ c. (Last) Jenkins			4. DATE OF DEATH (Month) (Day) (Year) July 25 1951					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) X		8. DATE OF BIRTH March 10, 1865		
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Tenn, /		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Un Known			13b. MOTHER'S MAIDEN NAME Un Known			14. NAME OF HUSBAND OR WIFE Widowed		
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. Un Known		17. INFORMANT'S SIGNATURE OR NAME Meta Juncal System Inc. ADDRESS 4653 Easton				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) 18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH Undet. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease Undet.								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H 91X				
22. I hereby certify that I attended the deceased from 7-18 , 19 51 , to 7-25 , 19 51 , that I last saw the deceased alive on 7-25 , 19 51 , and that death occurred at 8:10p m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) J. B. Foster M. D.				23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 7-26-51		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7/28/51		24c. NAME OF CEMETERY OR CREMATORY Little Rock		24d. LOCATION (City, town, or county) (State) Ark		
DATE REC'D BY LOCAL REG. AUG 28 1951		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE Royd Funeral Home ADDRESS 3704 Finney Ave				

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.....

Lucy E. Woodson

Signed.....
Student Embalmer

Licensed Embalmer No. *4341*

P. O. Address *St. Louis, 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.