

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19020**

No. 300
V. 10-48
FILED MAY 28 1952

BIRTH NO. _____ REG. DIST. NO. **322** PRIMARY REG. DIST. NO. **3071** Registrar's No. **25**

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Slater		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Slater 0971	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 117 E. Parker	
d. FULL NAME OF HOSPITAL OR INSTITUTION 117 E. Parker			

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) FRANCES c. (Last) JENKINS			4. DATE OF DEATH (Month) (Day) (Year) May 16 1952		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb 28 1897	9. AGE (In years last birthday) 55	IF OVER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Carroll Co. Mo	
12. CITIZEN OF WHAT COUNTRY USA					

13a. FATHER'S NAME George Elson		13b. MOTHER'S M maiden NAME Unknown		14. NAME OF HUSBAND OR WIFE Nathan W Jenkins	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ed Jenkins, New Witt 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis & failure		INTERVAL BETWEEN ONSET AND DEATH 10 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) failure		
	DUE TO (c) Generalized Arteriosclerosis		
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. of 221	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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 **Feb 4**, 1952 to **May 16**, 1952, that I last saw the deceased alive on **May 14**, 1952, and that death occurred at **4:06 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) C. A. McBurney, M.D.	23b. ADDRESS Slater, Mo.	23c. DATE SIGNED 5/16/52
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE May 18 1952	24c. NAME OF CEMETERY OR CREMATORY Evergreen Cem.	24d. LOCATION (City, town, or county) (State) New Witt, Mo
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DATE REC'D BY LOCAL REG. 5/19/52	REGISTRAR'S SIGNATURE Mr. Earl Cometz	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Standley Gibson Carrollton, Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

1971

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 Ben W Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton, Ga

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.