

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24436

State File No.

664

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. _____

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 town) OR TOWN <u>Springfield, Missouri</u>		c. LENGTH OF STAY (in this place) <u>2 months</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cave Springs, 0390</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home of his son 2617 North Delaware</u>		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Franklin</u> c. (Last) <u>Jennings</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 16, 1953</u>
5. SEX <u>Male 0</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Feb. 13, 1888</u>
9. AGE (In years last birthday) <u>65</u>		IF UNDER 1 YEAR (Months) <u>5</u>	IF UNDER 2 HRS. (Days) <u>3</u> (Hours) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Upholsterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Upholsterer</u>	11. BIRTHPLACE (State or foreign country) <u>Cave Springs, Missouri 0</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Richard H. Jennings</u>	
13b. MOTHER'S MAIDEN NAME <u>Margaret Chittim</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs Lula Jennings</u>	
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>No</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Lula Jennings, Cave Springs, Mo</u>
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 mos.</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		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 <u>May 15, 1953</u> , to <u>July 16, 1953</u> , that I last saw the deceased alive on <u>July 16, 1953</u> , and that death occurred at <u>9:40 pm.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>R. Wendell Stewart</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>219 Professional Bldg. Springfield, Mo</u>	23c. DATE SIGNED <u>July 19, 53</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 19, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Cave Springs Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Cave Springs, Missouri</u>
DATE REC'D BY LOCAL REG. <u>7/18/53</u>	REGISTRAR'S SIGNATURE <u>Edith Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Greenwade-Windle, Willard, Missouri.</u>	

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed James W. Wair

Licensed Embalmer No. 4650

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.