

FILED JUL 15 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19258

BIRTH NO. _____ REG. DIST. NO. 172 PRIMARY REG. DIST. NO. 3084 Registrar's No. 47

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Lafayette	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Higginsville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Higginsville, Mo. 0540	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 127 E 15th	

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) David c. (Last) Jennings			4. DATE OF DEATH (Month) (Day) (Year) 7 5 55		
5. SEX 0 male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2	8. DATE OF BIRTH Aug. 16, 1864	9. AGE (In years last birthday) 90	10. UNDER 1 YEAR Days 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and State or Foreign Country) Higginsville, Mo. 0	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME James Campbell Jennings	13b. MOTHER'S MAIDEN NAME. Nancy Rose	14. NAME OF HUSBAND OR WIFE Laura Kincheloe Dec.
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.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Grace Jennings Higginsville Mo

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Staphylococcal congestive pneumonia</i>		2 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Chronic myocardial degeneration</i> DUE TO (c)		1 year
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Fracture right femur</i>		10 mo.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
		4222 F	

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?

22. I hereby certify that I attended the deceased from Nov 4, 1954, to July 5, 1955, that I last saw the deceased alive on July 5, 1955, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edwin Wilson, M.D.	23b. ADDRESS 1815 Main Higginsville, Mo	23c. DATE SIGNED 7/7/55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-7-55	24c. NAME OF CEMETERY OR CREMATORY City Higginsville Mo.
24d. LOCATION (City, town, or county) (State)	24e. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Forrest H. Hooker Higginsville Mo	
DATE REC'D BY LOCAL REG. July 8, 1955	REGISTRAR'S SIGNATURE Clayton W. Lamberson 154	

(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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Forrest S. Hoyle

Licensed Embalmer No. 4358

P. O. Address Higginsville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.