

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

19642

State File No. _____

FILED JUN 25 1956

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **675**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give town(ship)) St. Joseph	c. LENGTH OF STAY (in this place) 20yrs	c. CITY OR TOWN St. Joseph	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 2614 So 19th Street		e. STREET ADDRESS (If rural, give location) 2614 So 19th Street	

3. NAME OF DECEASED (Type or Print)	a. (First) Jake	b. (Middle) E	c. (Last) Jennings	4. DATE OF DEATH (Month) (Day) (Year) June 21, 1956
---	------------------------	----------------------	---------------------------	---

5. SEX male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 18, 1877	9. AGE (In years last birthday) 79	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) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Service Station	11. BIRTHPLACE (City and State or Foreign Country) Rock Port, Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	---	--

13a. FATHER'S NAME Thomas Jennings	13b. MOTHER'S MAIDEN NAME Elizabeth Settles	14. NAME OF HUSBAND OR WIFE Ida Jennings, St. Joseph,
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY (If yes, give war or dates of service) no 486-30-2690	17. INFORMANT'S SIGNATURE OR NAME Ida Jennings St. Joseph, Mo	ADDRESS
--	--	--	----------------

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 10 1/2 not sure
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis 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 331x	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 June 10, 1956, to June 19, 1956, that I last saw the deceased alive on June 18, 1956, and that death occurred at 6:10 P.M., from the causes and on the date stated above.

23a. SIGNATURE Colles Rowlandy M.D.	(Degree or title)	23b. ADDRESS St. Joseph, Mo.	23c. DATE SIGNED June 21-56
--	-------------------	---	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/23/56	24c. NAME OF CEMETERY OR CREMATORY Maple Grove Cemetery	24d. LOCATION (City, town, or county) (State) Oregon Mo.
---	------------------------------------	--	---

DATE REC'D BY LOCAL REG. June 22, 1956	REGISTRAR'S SIGNATURE Eugene M. Allison	5. FUNERAL DIRECTOR'S SIGNATURE John E. Huff	ADDRESS St. Joseph, Mo
---	--	---	---

(Licensed Embalmer's Statement on Reverse Side)

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

300
48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb
by me, ~~8~~ by....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Alvin C. Bagan*
.....

Licensed Embalmer No. *479*

P. O. Address *Dr. J. J. J.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.