

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

47288
STATE FILE NUMBER
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6136

FILED JAN 17 1958

V. S. 300 D
Rev. 1-57

1. PLACE OF DEATH a. COUNTY JACKSON			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY Linne		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Linneus		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V.A. HOSPITAL		Length of stay in 1b 146 days	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) JAMES C. JENNINGS			4. DATE OF DEATH DEC. 24, 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 18, 1919	9. AGE (In years of birthday) 38	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ODD JOBS		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) BROWNING, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME GROVER C. JENNINGS		13b. MOTHER'S MAIDEN NAME BERTHA JANE THARP		14. NAME OF HUSBAND OR WIFE MAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 339-16-8482	17. INFORMANT Address Official Records - VA Hospital, K.C., Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Tuberculosis, pulmonary, active, bilateral				0027	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Involvement of adrenal glands				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. V.A. attended the deceased from July 31, 1957 to Dec. 24, 1957 Death occurred at 1:30 PM m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE E. Foroughi (Degree or title) D			22b. ADDRESS M.D. VA Hospital, Kansas City, Mo.		22c. DATE SIGNED 12-25-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/26/57	23c. NAME OF CEMETERY OR CREMATORY Locust Valley		23d. LOCATION (City, town, or county) (State) Browning, Mo	
24. FUNERAL DIRECTOR Sheil Funeral Home, K.C Mo.		25. DATE RECD. BY LOCAL REG. 12-26-57	26. REGISTRAR'S SIGNATURE Neva Marshall		

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION



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
Signature of Student Embalmer

Signed Blake Glidden

Licensed Embalmer No. 5019
P. O. Address Laclede 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.