

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013269

STATE FILE NUMBER

FILED MAY 5 1958

Registration District No. 38 Primary Registration District No. 5122 Registrar's No. 200

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| 1. PLACE OF DEATH a. COUNTY <u>Boone</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <u>0100</u> a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rockey Fork Township</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN <u>Sturgeon, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>8 miles S. Sturgeon</u> | | Length of stay in 1b <u>28 yrs.</u> | d. STREET ADDRESS (If outside, give location) <u>Route 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Amos</u> Middle <u>L.</u> Last <u>Jennings</u> | | | 4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1958</u> | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 18, 1868</u> | 9. AGE (In years last birthday) <u>89</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | 11. BIRTHPLACE (City and state or country) <u>Boone County, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |

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| 13a. FATHER'S NAME <u>James Jennings</u> | | 13b. MOTHER'S MAIDEN NAME <u>Betsy Coats</u> | | 14. NAME OF HUSBAND OR WIFE <u>Mattie 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. ----- | 17. INFORMANT <u>Hubert Jennings Sedalia, Mo.</u> Address | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Carcinoma of esophagus</u> | | |
| | DUE TO (c) _____ | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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. _____ | | | | | |

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| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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. I attended the deceased from <u>17 April 58</u> to <u>24 April 58</u> and last saw her/him alive on <u>24 April 58</u> Death occurred at <u>5:40 P m</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |

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| 22a. SIGNATURE (Degree, if any) <u>James Jennings M.D.</u> | | 22b. ADDRESS <u>202 So. 10th Columbia</u> | 22c. DATE SIGNED <u>2 May '58</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | 23b. DATE <u>5/3/58</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Columbia, Missouri</u> |
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| 24. FUNERAL DIRECTOR <u>Lyman Sprinkle Columbia, Mo.</u> | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>May 2 1958</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u> |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MS JAN 4 1960

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, ~~XXX~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *[Handwritten Signature]*

Licensed Embalmer No. *4425*
P. O. Address *Columbia, 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.