

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS AUG 7 1959

**59-024580**

STATE FILE NUMBER

Registration District No. 7 Primary Registration District No. 4140 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>EUGENE</u>	Length of stay in 1b <u>3 YRS</u>	c. CITY OR TOWN <u>EUGENE</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>EUGENE</u>		d. STREET ADDRESS <u>EUGENE</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>ISAAC- ANDERSON- JENKINS</u>			4. DATE OF DEATH Month Day Year <u>Aug- 3 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>21 Nov-1896</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (City and state or country) <u>MILLER- Co- Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>

13a. FATHER'S NAME <u>BENJAMIN- JENKINS</u>		13b. MOTHER'S MAIDEN NAME <u>SARBAH- SPYRES</u>		14. NAME OF HUSBAND OR WIFE <u>CORA- BOND- JENKINS</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>NONE</u>		17. INFORMANT <u>Thelma- Roberts- Eugene- Mo</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.....

IMMEDIATE CAUSE (a) Mycobacterium chronic

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) \_\_\_\_\_

DUE TO (c) \_\_\_\_\_

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  Unknown

INTERVAL BETWEEN ONSET AND DEATH 2 yr

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>NONE</u>
---	---	---

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>NONE</u>	20d. INJURY OCCURRED WHILE AT WORK <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.) <u>NONE</u>	20f. CITY, TOWN, OR LOCATION <u>NONE</u>	COUNTY	STATE
--	--	---	---	--------	-------

21. I attended the deceased from 7-31-59 to 8-3-59 and last saw her/him alive on 8-1-59.  
Death occurred at 8:20 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>M. E. Humphrey</u>	(Degree or title) <u>DO</u>	22b. ADDRESS <u>Tuscumbia- Mo</u>	22c. DATE SIGNED <u>4 Aug- 59</u>
---	--------------------------------	--------------------------------------	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL-</u>	23b. DATE <u>6 Aug- 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SPRING- GARDEN-</u>	23d. LOCATION (City, town, or county) <u>Miller- Co- Mo</u>
---	---------------------------------	--	--

24. FUNERAL DIRECTOR <u>Keith M. Keys</u>	ADDRESS <u>ELDON- Mo</u>	25. DATE RECD. BY LOCAL REG. <u>4 August 1959</u>	26. REGISTRAR'S SIGNATURE <u>R. P. Harris, MD MR</u>
--	-----------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Keith McKay

Licensed Embalmer No. 399

P. O. Address Eldon

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.