

RIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029869

STATE FILE NUMBER

FILED AUG 27 1959
 Registration District No. 40 Primary Registration District No. 4359 Registrar's No. 18

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lilbourn</u> Length of stay in lb _____ c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ewing Ave.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u> c. CITY OR TOWN <u>Lilbourn</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Ewing Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Zack</u> Middle <u>Jennings</u> Last _____			4. DATE OF DEATH Month <u>Aug.</u> Day <u>10</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</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>6-1-1877</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>9</u> 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>Pensioner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Federal, Tennessee</u>		11. BIRTHPLACE (City and state or country) <u>U. S. A.</u>			
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Fanger Jennings</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Fanger Jennings-Lilbourn, Mo.</u> Address _____			
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>Carcinoma of Larynx</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>		
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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.) _____					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>8-9-59</u> to <u>8-10-59</u> and last saw her/him alive on <u>8-10-59</u> Death occurred at <u>6:20 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>J. C. Camera</u> (Degree or title) _____			22b. ADDRESS <u>Lilbourn Mo</u>		22c. DATE SIGNED <u>8-11-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-13-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sandhill Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Near New Madrid, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Ponder Funeral Home Lilbourn, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>8-12-1959</u>		26. REGISTRAR'S SIGNATURE <u>H. L. Ponder Deputy</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

WEST VIRGINIA COLLEGE OF HEALTH SCIENCES

1971
February 24

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 Harold S. Ponder

Licensed Embalmer No. 5030
P. O. Address Lilburn, Ga.

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.