

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-029714

FILED VS SEP 12 1960

042

1000

936

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 49 yrs.	c. CITY OR TOWN St. Joseph
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph State Hospital 2		# 4 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2335 So. 6th Street
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First ANDREW Middle JACKSON Last JENKINS			4. DATE OF DEATH Month September Day 5 Year 1960			
--	--	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/23/1880	9. AGE (last birthday) 79 yrs.	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) Ret. Merchant	10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	11. BIRTHPLACE (City and state or country) Galena, Kansas	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	---	---	--

13a. FATHER'S NAME Andrew J. Jenkins	13b. MOTHER'S MAIDEN NAME Hannah C. Wiggins	14. NAME OF HUSBAND OR WIFE None
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 491-28-2693A	17. INFORMANT Mrs. Charlotte Morris, St. Joseph, Mo	Address 3101 Mitchell Ave
---	--	---	-------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Bronchial Pneumonia		2 days +
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis	10 yrs. +
	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. <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 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 **9-5-1960** to **9/5/1960** and last saw him alive on **9/5/1960**
Death occurred at **9:30 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. E. Cassins M.D.	22b. ADDRESS State Hospital # 2 St. Joseph, Missouri	22c. DATE SIGNED 9/5/1960
---	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/7/1960	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) St. Joseph, Missouri
--	------------------------------	---	--

24. FUNERAL DIRECTOR Stamen Funeral Home	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. September 6, 1960	26. REGISTRAR'S SIGNATURE Mr. Charles Goodell
--	-----------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF **C. E. Cassins, M.D.** 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 Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph

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.