

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 19 1960

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962

-60-033897

STATE FILE NUMBER

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

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY Buchanan		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		a. STATE Missouri		b. COUNTY Buchanan	
Length of stay in 1b life		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 3302 Belt View Drive	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3302 Belt View Drive		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 3302 Belt View Drive		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BETTY LOU JENNINGS				4. DATE OF DEATH Month Day Year September 10, 1960			
5. SEX female	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 10/21/1923	9. AGE (last birthday) 36	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee		10b. KIND OF BUSINESS OR INDUSTRY Anchor Serum Co.		11. BIRTHPLACE (City and state or country) St. Joseph, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Earl Ford		13b. MOTHER'S MAIDEN NAME Bertha Mitchell		14. NAME OF HUSBAND OR WIFE Walter Jennings			
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. 499-16-5734		17. INFORMANT Address Walter Jennings, 3302 Belt View Dr. St. Joseph			
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) Respiratory failure						2 hours	
DUE TO (b) Injection of 30 mebratins tabs						2 hrs	
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 checked="" type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Dependent			
20c. TIME OF INJURY Hour s.m. 1:00 p.m. Month, Day, Year Sept 10 60		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.) 3302 Beltview drive St. Joe Buchanan Mo		20f. CITY, TOWN, OR LOCATION St. Joseph		COUNTY Buchanan		STATE Mo	
21. I attended the deceased from viewed body and last saw her alive on Sept 10-60 Death occurred at 2:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) S.E. Meluney M.D.				22b. ADDRESS 214 N. 1st St. St. Joseph, Mo		22c. DATE SIGNED Sept 12 60	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 9/12/1960		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph Mo.	
24. FUNERAL DIRECTOR Heaton-Bowman			ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Sept. 14, 1960		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

DOCUMENT

S.E. Meluney M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 7 1967

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 314 S 10th St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.