

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-002025

FILED VS FEB 7 1961

170

Primary Registration District No.

56 db

Registrar's No. 20

STATE FILE NUMBER

AMENDED

1. PLACE OF DEATH a. COUNTY <b>Laclede</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Laclede</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Eldridge</b>		Length of stay in 1b <b>10</b> days	c. CITY OR TOWN <b>Eldridge</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Eldridge</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Eldridge</b>		
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>THOMAS</b> Last <b>JENNINGS</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>25</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-6-61</b>	9. AGE (last birthday) IF UNDER 1 YEAR Months <b>19</b> IF UNDER 24 HR Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Jefferson City, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Thomas H. Jennings</b>			13b. MOTHER'S MAIDEN NAME <b>Delores Hicks</b>		14. NAME OF HUSBAND OR WIFE <b>None.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Thomas Jennings, Eldridge, Mo.</b>			
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) <b>Medullary Paralysis</b>					<b>5 min.</b>	
Increased intracranial pressure					<b>since birth</b>	
DUE TO (b) <b>Internal Hydrocephalus</b>					<b>since birth</b>	
DUE TO (c) <b>Congenital amonolies of Spinal Membranes.</b>					<b>since birth</b>	
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 <b>Jan 24, 1961</b> to <b>Jan 25, 1961</b> and last saw her alive on <b>Jan 24, 1961</b> Death occurred at <b>7:30 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>Kenneth E. Mitchem MD.</b>			22b. ADDRESS <b>Camdenton, Mo</b>		22c. DATE SIGNED <b>Jan 28, 1961</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/30/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hufft Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Laclede County Mo.</b>	
24. FUNERAL DIRECTOR <b>J.R. Palmer</b>		ADDRESS <b>Lebanon, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>1-30-1961</b>		26. REGISTRAR'S SIGNATURE <b>Hella L. May</b>	

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed Stanley B. Palmer

Licensed Embalmer No. 4810

P. O. Address Lebanon, 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.