

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County Henry  
Township Springfield  
or  
Village  
or  
City (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 356 File No. 9211  
Primary Registration District No. 5500 Registered No. 141

FULL NAME Charles Franklin Jennings  
[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed  
(# write the word)

DATE OF BIRTH April 18, 1863  
(Month) (Day) (Year)

AGE 50 yrs. 8 mos. 15 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) Farming

BIRTHPLACE (City or town, State or foreign country) Henry Co. Mo.

PARENTS  
NAME OF FATHER Jefferson Jennings  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Missouri  
MAIDEN NAME OF MOTHER Elizabeth Bradley  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) J. C. Jennings  
(ADDRESS) Hudson Mo.

Filed Jan 3 1914 J. P. Allen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 3, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 15, 1913, to Jan 3  
that I last saw him alive on Jan 3  
and that death occurred, on the date stated above, at \_\_\_\_\_

The CAUSE OF DEATH\* was as follows:  
Acute Nephritis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) R. J. Jennings M. D.  
Jan 3 1914 (Address) Hudson Mo.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL St. Louis DATE OF BURIAL Jan 4 1914  
UNDERTAKER W. E. Hutton ADDRESS Hudson Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH

County \_\_\_\_\_ Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 or Village \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 or \_\_\_\_\_ (NO. \_\_\_\_\_)  
 City \_\_\_\_\_  
 [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX \_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_  
 COLOR OR RACE \_\_\_\_\_ WIDOWED \_\_\_\_\_ OR DIVORCED \_\_\_\_\_  
 (If / in the word)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
 \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 IF LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min.?

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

NAME OF FATHER \_\_\_\_\_ M. D. \_\_\_\_\_

BIRTHPLACE OF FATHER (City or town, State or foreign country) \_\_\_\_\_

MAIDEN NAME OF MOTHER \_\_\_\_\_

BIRTHPLACE OF MOTHER (City or town, State or foreign country) \_\_\_\_\_

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) \_\_\_\_\_ (Address) \_\_\_\_\_ M. D. \_\_\_\_\_

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) \_\_\_\_\_ In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Where was disease contracted if not at place of death? \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_  
 (ADDRESS) \_\_\_\_\_ DATE OF BURIAL OR REMOVAL \_\_\_\_\_ ADDRESS \_\_\_\_\_  
 UNDERTAKER \_\_\_\_\_

Filed \_\_\_\_\_, 191\_\_\_\_ REGISTRAR \_\_\_\_\_