

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

REC'D JUL 10 1939

21130  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 399  
 (b) Township Yew Primary Registration District No. 1002 Registered No. 24077  
 (c) City N. C. Mo. (d) Street No. General Hospital #2 St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Opal Jenkins  
 (a) Residence, No. 5311 Prospect St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William Jenkins

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-23-1914

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>24</u>	<u>6</u>	<u>22</u>	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

FATHER  
 13. NAME William Waters  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

MOTHER  
 15. MAIDEN NAME Jenny Madison  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

17. INFORMANT Record Clerk  
 (ADDRESS) General Hospital #2

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Lincoln DATE 6-13-1939

19. FUNERAL DIRECTOR (NAME) Wing + Brady  
 (ADDRESS) 1513 Troost

20. FILED 6/12 1939 M. D. Brown  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-8, 1939

22. I HEREBY CERTIFY, That I attended deceased from 6-5, 1939, to 6-8, 1939  
 I last saw her alive on 6-8, 1939. Death is said to have occurred on the date stated above, at 1:15 P. M.  
 The principal cause of death and related causes of importance were as follows:  
Partum Eclampsia  
131  
 Other contributory causes of importance:  
Nephritis, Chronic

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? 1  
 If so, specify \_\_\_\_\_  
 (Signed) A. C. Brown, M. D.  
 (Address) General Hospital #2



**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 \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed L. Harris, Jr.  
Licensed Embalmer No. 3588

P. O. Address \_\_\_\_\_

**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 this body is not embalmed, above space should be left blank.**