

Whelan

DEC 12 1939

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

40489
Do not use this space.

1. PLACE OF DEATH

(a) County Pettis Registration District No. 668
(b) Township Sedalia Primary Registration District No. 9099 Registered No. 316
(c) City Sedalia (d) Street No. 2704 So. Ohio 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 Arthur A. Jens

(a) Residence, No. 2704 So. Ohio 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary U. Jens

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 22, 1896

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
43 5 21

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

12. BIRTHPLACE (CITY OR TOWN) Lincoln (STATE OR COUNTRY) Neb.

FATHER 13. NAME Chris F. Jens

14. BIRTHPLACE (CITY OR TOWN) Germany (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Caroline Holtz

16. BIRTHPLACE (CITY OR TOWN) Milwaukee (STATE OR COUNTRY) Wis.

17. INFORMANT Mrs. Mary U. Jens (ADDRESS) Sedalia, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Crown Hill DATE Nov. 15, 1939

19. FUNERAL DIRECTOR (NAME) Gillespie Funeral Home (ADDRESS) Sedalia, Mo.

20. FILED Nov 14 19.39 Mr. Harry Sneed Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 13, 1939 1939

22. I HEREBY CERTIFY, That I attended deceased from June 5, 1939 to Nov. 13, 1939

I last saw him alive on NOV. 8, 1939. Death is said to have occurred on the date stated above, at 8 a.m.

The principal cause of death and related causes of importance were as follows:

Carcinoma Date of onset

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? laboratory Where an autopsy? No

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? No
If so, specify.....

(Signed) Whelan M. D.
(Address) Sedalia, Mo.

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.

WRITE PLAINLY

I X 16605

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STATE DIVISION
OF HEALTH SERVICE

RECEIVED FILED STATE OFFICE
INDEX CARD RETURNED TO DISTRICT
DATE 11/15/67

OCT 15 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 me, or by.....

L. E. Bouldin

Registered Apprentice No.....

working under my personal supervision.

Signed.....

L. E. Bouldin

Licensed Embalmer No.....

3867

P. O. Address.....

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

40489

Do not use this space.

1. PLACE OF DEATH *Ottis*

(a) County *Ottis* Registration District No. *668*

(b) Township *Sedalia* Primary Registration District No. *3032* Registered No. _____

(c) City *Sedalia* (d) Street No. _____ 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 *Arthur A. Jones*

(a) Residence, No. _____ 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 *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *M*
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<i>43</i>	<i>5</i>	<i>21</i>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

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) _____

FATHER

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov 13* 19*39*

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Cardiomyopathy

Involving soft tissue between scapula and ribs of left side of thorax. Afterwards a metastasis to lymph glands of thorax and abdomen.

Date of onset *6-5-39*

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____

If so, specify _____

(Signed) *W. M. Wheeler*, M. D.
(Address) _____

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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.

Local Registrar.

1971 5 1346