MARGIN RESERVED FOR BINDING

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: Vernon

Township: Montevallo — Registration District No. 873 — File No. 17492

or Village: — Primary Registration District No. 6157 — Registered No.

or City: (NO. St.: Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Walter S Mann

PERSONAL AND STATISTICAL PARTICULARS

SEX: male — COLOR OR RACE: white — SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): single

DATE OF BIRTH: September 18, 1879 (Month) (Day) (Year)

AGE: 37 yrs. 7 mos. 2 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): Vernon Co. Mo

PARENTS
NAME OF FATHER: Warren R Mann
BIRTHPLACE OF FATHER (City or town, State or foreign country): Cedar Co Mo
MAIDEN NAME OF MOTHER: Sarah C Price
BIRTHPLACE OF MOTHER (City or town, State or foreign country): North Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W R Mann

(ADDRESS) Montevallo Mo

Filed April 4 1917. Sarah E Closser, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April 3, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 28, 1917, to April 3, 1917, that I last saw him alive on April 3, 1917, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Lobar
GN

(Duration) yrs. mos. 8 ds.

Contributory (SECONDARY): Indigestion

(Duration) 2 yrs. mos. ds.

(Signed) C B Dean M. D.

4-4-1917 (Address) Montevallo 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: Virgil Cemetery — DATE OF BURIAL: April 4. 1917

UNDERTAKER: Siders Siders — ADDRESS: El Dorado Springs

MARGIN RESERVED FOR BINDING

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 _____

Township _____ or Village _____ or City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

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

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____, *1*_____ (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, _____ hrs. or _____ min.?

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) _____

PARENTS
- NAME OF FATHER _____
- BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
- MAIDEN NAME OF MOTHER _____
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____ _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), *191*____ (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:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____ (SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*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	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS