

N. B. 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.

1928

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

Do not use this space.

14435

1. PLACE OF DEATH

County Putnam

Registration District No. 718

File No. _____

Township _____

Primary Registration District No. 6480

Registered No. 71

City Unionville (No. _____) St. _____ Ward _____

2. FULL NAME

Pliny M. Mannon

(a) Residence. No. _____ St. _____ Ward _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

MARRIED.

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

Esther Peiffer Mannon

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

May 10 1849

7. AGE

YEARS 78

MONTHS 10

DAYS 28

IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Retired Hammer.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Unionville, Mo.

(STATE OR COUNTRY)

10. NAME OF FATHER

John H. Mannon

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Ind.

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

A. Hinson Hill

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Ind.

(STATE OR COUNTRY)

14.

INFORMANT (Address)

E. W. Mannon Unionville, Mo.

15.

FILED

4/9 1928

A. H. Johnson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-8 1928

17. I HEREBY CERTIFY That I attended deceased from April 6, 1928, to April 8, 1928. I examined him alive on April 5, 1928, and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

921
Arterio Sclerosis
91B
 CONTRIBUTORY removal of left testis
 (SECONDARY) stroke at leg

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) John Peiffer Jones, M. D.
4/9, 1928 (Address) Unionville Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE of INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Unionville Cemetery

DATE OF BURIAL

Apr 10 1928

20. UNDERTAKER

F. O. HUSTED & SON

ADDRESS

Unionville Mo.

PHYSICIAN'S REPORT
DATE: 10/15/50
PATIENT: J. W. BROWN
AGE: 45
SEX: M
OCCUPATION: Farmer
Address: 123 Main St., Anytown, U.S.A.

History of Present Illness: The patient reports a gradual onset of weakness and fatigue over the past several months. He has experienced a 10% weight loss and has noticed a decrease in his energy levels. There is no history of trauma, recent surgery, or acute illness. The patient has a long-standing history of hypertension, which is currently well-controlled with medication. He has no known allergies and is a non-smoker. His diet is a typical rural diet, and he has no known food intolerances. He has a family history of heart disease and diabetes.

Physical Examination: On admission, the patient was found to be in good health. He was well-developed and well-nourished. His vital signs were stable. The heart, lungs, and abdomen were normal. There were no abnormalities noted on the physical examination.

Investigations: A complete blood count (CBC) and a comprehensive metabolic panel (CMP) were ordered. The CBC showed a normal hemoglobin level and a normal white blood cell count. The CMP showed a normal electrolyte panel and a normal renal function. A chest X-ray and an electrocardiogram (ECG) were also performed, both of which were within normal limits.

Diagnosis: The patient's symptoms are consistent with a diagnosis of chronic fatigue syndrome. This is a complex condition characterized by persistent and debilitating fatigue that is not relieved by rest. The patient's symptoms are not attributable to any other medical condition, and there is no evidence of a major medical problem.

Management: The patient was advised to continue with his current medical management, including his hypertension medication. He was encouraged to engage in light physical activity and to maintain a regular sleep schedule. Psychological support and counseling were recommended to help the patient cope with his symptoms. A follow-up appointment was scheduled for one month later to reassess his condition.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Putnam

Registration District No. 718

File No. 14433-

Township Unionville

Primary Registration District No. 6420

Registered No. 21

City Unionville (No. St. Ward

2. FULL NAME

Olin M. Mannon

(a) Residence. No. St. Ward. (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED Aug 10 1926 J. H. Halman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 8 1928

17. I HEREBY CERTIFY That I attended deceased from 19..... that I last saw him alive on 19..... and that death occurred, on the date stated, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute Bacteremia
Cerebral Hemorrhage
apoplexy

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, DATE OF

DID AN OPERATION PRECEDE DEATH, DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

N. B. —Every item of info. should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in particular, so that it may be properly classified. A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-14435