

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

Do not use this space.

32599

1. PLACE OF DEATH  
 County North Registration District No. 905-  
 Township Allen Primary Registration District No. 6216 File No. \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 Registered No. \_\_\_\_\_

2. FULL NAME Amos A. Manning  
 (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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Martha Manning  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
86 11 25  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work farmer  
 (b) General nature of industry, business, or establishment in which employed. (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Pennsylvania  
 (STATE OR COUNTRY)  
 10. NAME OF FATHER Jacob Manning  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Pa.  
 (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER Rachel Arnold  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Pa.  
 (STATE OR COUNTRY)

14. INFORMANT J. J. Brown  
 (Address) Denver, Mo.  
 15. FILED Oct 9, 1928 Mrs. Mays Long  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sep. 9, 1928  
 17. I HEREBY CERTIFY That I attended deceased from 29 1928 to Sept 9 1928  
 that I last saw him alive on Sept 9 1928 and that death occurred, on the date stated above, at 3-30 A m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Intestinal influenza  
IIB  
 (duration) yrs. mos. ds. 10

CONTRIBUTORY (SECONDARY) IIB  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_

0 DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? No  
 WHAT TEST CONFIRMED DIAGNOSIS? Physical postmortem  
 (Signed) Lewis W. Lang M. D.  
 , 19 (Address) Denver, 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 Prairie Chapel DATE OF BURIAL Sept. 11, 1928  
 20. UNDERTAKER Moore Bros ADDRESS Denver

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.

... of ... ..  
... ..  
... ..  
... ..

**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 Worth Registration District No. 905 File No. ....  
Towship Allen Primary Registration District No. 6216 Registered No. ....  
City (No. ....) St. .... Ward)

**2. FULL NAME** Amos A. Manning  
(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. 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) W.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1841-9-14

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>86</u>	<u>11</u>	<u>25</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) yrs. mos. ds.  
(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 Oct 9 18 1918 Mrs. Maye Long REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 9 19 28

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) ..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

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

19

20. UNDERTAKER

ADDRESS

X. B. Every item of information should be carefully verified. 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. SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW REGIS'

SUPPLEMENTARY

2-32549