A) 23 1929

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

Do not use this space. 14012

1. PLACE OF DEATH
County Butler — Registration District No. 89 — File No.
Township Poplar Bluff — Primary Registration District No. 3067 — Registered No. 91
City Poplar Bluff (No. ..... St. ..... Ward)

2. FULL NAME James Edward Mann
(a) Residence. No. 325 North D. St. St., 4th Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 8 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 (write the word): single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 26, 1929

7. AGE: Years 8 — Months 2 — Days 04 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Poplar Bluff
(STATE OR COUNTRY) Missouri Butler Co.

PARENTS
10. NAME OF FATHER Sam Mann
11. BIRTHPLACE OF FATHER (CITY OR TOWN) McLeansburg
(STATE OR COUNTRY) Ill.
12. MAIDEN NAME OF MOTHER Ester Mann
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Ark.

14. INFORMANT Sam Mann
(Address) 325 North D St. Poplar Bluff

15. FILED 5/1, 1929 Dr B J Cline REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 30, 1929

17. I HEREBY CERTIFY, That I attended deceased from April 11, 1929, to April 30, 1929 that I last saw b[illegible] alive on April 30, 1929, and that death occurred, on the date stated above, at 10 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1 18B Typhoid fever (duration) yrs. 1 mos. ds.

CONTRIBUTORY (SECONDARY) Encephalitis (duration) yrs. mos. 20 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Same
DID AN OPERATION PRECEDE DEATH? no. DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Laboratory
(Signed) J Lee Harwell, M.D.
5/1, 1929 (Address) Poplar Bluff 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: Brosley, Mo. — DATE OF BURIAL: May 2 1929

20. UNDERTAKER: R. W. Green Poplar Bluff, Mo. — ADDRESS

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE . PRESCRIBED BY LAW

1. PLACE OF DEATH

County: Butler — Registration District No.: 89 — File No.:

Township: — Primary Registration District No.: 3007 — Registered No.: 9

City: Poplar Bluff (No. ..... St. ..... Ward)

2. FULL NAME Jonnie Edward Mann

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 26 1921

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	8	2	4	

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)

PARENTS
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 4/6, 1929 Dr BJ Camp
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 30 1929

17. I HEREBY CERTIFY, That I attended deceased from..... 19..... to..... 19.....
that I last saw h..... alive on..... 19....., 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.

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

SUPPLEMENTARY

S-14012