

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

Do not use this space.

40192

1. PLACE OF DEATH

County West
Township _____
City Salus (No. _____)

Registration District No. 366
Primary Registration District No. 3168

File No. _____
Registered No. 82
St. _____ Ward _____

2. FULL NAME

Nancy A. Manning

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 20th 1850

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>79</u>	<u>10</u>	<u>11</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Tenn.

10. NAME OF FATHER Benj. Mitchell

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

12. MAIDEN NAME OF MOTHER Nancy Jarnall

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

14. INFORMANT Mrs. R. E. Griffin
(Address) Salus, Mo.

15. FILED 1/2 1930 W. E. Rudd REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 31st 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1st 1925 to Dec. 31st 1929, that I last saw her alive on 12/29 1929, and that death occurred, on the date stated above, at 11 AM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Oedema of Lungs
9-2A
1015
(duration) _____ yrs. _____ mos. 10 ds.

CONTRIBUTORY (SECONDARY) Endo Carditis
(duration) 5 yrs. _____ mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? usual Physical
(Signed) W. E. Rudd, M. D.

. 19 (Address) Salus, 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 Walford Cemt. DATE OF BURIAL 1/2 1930

20. UNDERTAKER N. A. Hobson ADDRESS Salus, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and STATE REGISTRARS should be notified of this death.

235
2

33
21
2
2
1930

100 12 11

Feb 20 - 1870

RECEIVED
FEB 20 1870

1870

1870