MAR 28 1930

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

Do not use this space.

2130

1. PLACE OF DEATH
County Pemiscot Registration District No. 651
Township Little Prairie Primary Registration District No. 5862
City ..... (No. ..... St. ..... Ward)

File No. .....
Registered No. 27

2. FULL NAME Floyd William 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 Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) ✓

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-11-1929

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	11	29	

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) Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Clatus B. Mann
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Enter Mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mable Lee
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)

14. INFORMANT Clatus B. Mann
(Address) Caruthersville

15. FILED Feb. 25 1930 Ada Martin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/10 1930

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 2 ... min.
THE CAUSE OF DEATH* WAS AS FOLLOWS: unknown
No attending Physician
2003
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) 2053
(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) Fred L. Ogilvie, H. D. M.D.
Feb. 25 1930 (Address) Caruthersville 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 Maple Cemetery
DATE OF BURIAL 1/11 1930

20. UNDERTAKER H S Smith
ADDRESS Cville Mo

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.