

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

DEC 22 1930

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

Do not use this space.

36496

1. PLACE OF DEATH

County Jasper

Registration District No. 400

Township Marion

Primary Registration District No. 8020

City McCune Breaks Hospital (Name) Centennial (Number)

2. FULL NAME

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

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 da. How long in U. S., if of foreign birth? 7 yrs. 0 mos. 0 da.

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) Nov. 12, 1864

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 0 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Bank Teller

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) West Union (STATE OR COUNTRY) Ohio

10. NAME OF FATHER Andrew J. Mannon

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

12. MAIDEN NAME OF MOTHER Elizabeth M. Clay

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

14. INFORMANT Mrs. Jennie King (Address) Palmer Block Carthage, Mo

15. FILED Nov 14 1930 OT Hetcham REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 13 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Nov 12, 1930 that I last saw him alive on Nov 12, 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Embolism of Stomach
Artificial Sclerosis
(duration) 2 yrs. X mos. X da.
CONTRIBUTORY (SECONDARY) _____ (duration) _____

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? no X Yes
WHAT TEST CONFIRMED DIAGNOSIS? as in "a"
(Signed) David Hase M. D.
, 19 _____ (Address) Carthage 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 Park Cemetery DATE OF BURIAL Nov. 15 1930

20. UNDERTAKER Knee Mortuary ADDRESS Carthage Missouri

