NOV 26 1930

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

Do not use this space.

36700

1. PLACE OF DEATH
County Lincoln — Registration District No. 972 — File No. 9
Township — Primary Registration District No. 5652 — Registered No. 9
City Moscow (No. ..... St. ..... Ward)

2. FULL NAME Herman Mankel
(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 20 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: Single
6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 2nd 1868
7. AGE: Years 62 — Months 5 — Days 29 — If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Day Labor
(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) Germany

PARENTS
10. NAME OF FATHER: Herman Mankel
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER: Ida Kruse
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Germany

14. INFORMANT: Mrs Mankel
(Address) Moscow Mills Mo

15. FILED Nov 2, 1930 H A Shepherd M D REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov 1 1930
17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1930, to Nov 1, 1930, that I last saw him alive on Nov 1, 1930, and that death occurred, on the date stated above, at 6 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Parenchymatous Nephritis
Followed by Uremic Coma, and
Paralysis
Duration (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Nephritis
(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? N.D.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) H A Shepherd, M. D
Nov 1, 1930 (Address) Moscow Mills 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: Anderson Cemetery — DATE OF BURIAL: Nov 3 1930
20. UNDERTAKER: Kempen Bros. — ADDRESS: Troy 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.

STATE PLANE WITH UNFADING INK—THIS IS A PERMANENT RECORD