

REC'D SEP 21 1938

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

28902
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 316
(b) Township _____ Primary Registration District No. 2001 Registered No. 640
(c) City Springfield (d) Street No. St. John's Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town, where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. Marshfield, Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 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) March 13, 1919

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
✓ 19 5 3

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
10. Date deceased last worked at this occupation (month and year) June 1938 11. Total time (years) spent in this occupation life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Webster Co.

FATHER 13. NAME Elmer Manning

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Webster Co.

MOTHER 15. MAIDEN NAME Naisy Mae Hartman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

17. INFORMANT (ADDRESS) Elmer Manning
Marshfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mission Home DATE Aug 17, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Rev. A. J. Rainey
Marshfield, Mo.

20. FILED Aug 17, 1938 Chas. A. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 16, 1938

22. I HEREBY CERTIFY, That I attended deceased from July 16, 1938, to Aug 16, 1938
I first saw him alive on Aug 16, 1938 Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Multiple Lung Abscesses (Date of onset Feb 1938)
(Vincent's & Frazer Bailler)

Other contributory causes of importance: 10/12
Pyogenic was apparently the etiology of the abscess + alone also long standing

Name of operation None Date of _____
What test confirmed diagnosis? Spec Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____

(Signed) J. L. Johnston M. D.

(Address) 800 Med. Coll. Bldg
Springfield, Mo.

STATE OF MISSOURI
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No., working under my personal supervision.

Signed, *For Stanley*

Licensed Embalmer No. 3312

P. O. Address. Marshfield, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

28907
Do not use this space.

1. PLACE OF DEATH
 (a) County Greene Registration District No. 318
 (b) Township Primary Registration District No. 2001 Registered No. 640
 (c) City Springfield (d) Street No.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Claude Longo Manning
 (a) Residence, No. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) s

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
19 5 3

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 16 1958

22. I HEREBY CERTIFY, That I attended deceased from to

I last saw h. alive on, 19..... Death is said to have occurred on the date stated above, at..... m.
 The principal cause of death and related causes of importance were as follows:
multiple lung abscess
pneumonia, bronchial

Other contributory causes of importance:

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury, 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify (Signed) J. J. Johnston M. D.
 (Address) 800 med. app Bldg Springfield Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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Local Registrar.

