FEB 7 1939

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

2491
Do not use this space.

OF DEATH

( ) County Howell — Registration District No. 384

(b) Township — Primary Registration District No. 4227 — Registered No.

(c) City West Plains — (d) Street No. Christa Hogan 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. 1 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Hurbert Allison Mann

(a) Residence, No. St. Kansas City, 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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 13, 1896

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
42	5	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. onst. Engineer
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) Zinc, Ark.

FATHER

13. NAME Not known
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mass.

MOTHER

15. MAIDEN NAME - - Ellis
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

17. INFORMANT Mrs. Pearl Burkhart
(ADDRESS) Searcy, Ark.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Bergman, Ark. DATE Jan. 19 1939

19. FUNERAL DIRECTOR Robertsons' Mortuary
(ADDRESS) West Plains, Mo.

20. FILED 1-18 1939 Vida M. Simons
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 17 1939

22. I HEREBY CERTIFY, That I attended deceased from 1/17 1939 to 1/17 1939
I last saw him alive on 1/17 1939. Death is said to have occurred on the date stated above, at 12:30 P.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Head & chest injuries, compound fracture left arm and right leg	1/17/ 1939

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury 1/17 1939
Where did injury occur Hy #63, Howell Co., Mo.
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Public place
Manner of injury Auto wreck
Nature of injury Head & chest injuries

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) [illegible], M. D.
(Address) West Plains, Mo.

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

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

I X12004

210 [illegible]

STATEMENT BY LICENSED EMBALMER

I, Paige H Robertson, Licensed Embalmer No. 3435

hereby certify that the body recorded on the reverse side of this certificate was embalmed by my self

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed Paige H Robertson

Licensed Embalmer No. 3435

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.)

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

2494
Do not use this space.

1. PLACE OF DEATH
(a) County Howell Registration District No. 384
(b) Township Primary Registration District No. 4227 Registered No.
(c) City West Plains (d) Street No. 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 Hurbert Allison Mann
(a) Residence, No. St.
(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): Div

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

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

7. AGE: Years 42 | Months 5 | Days 4 | If LESS than 1 day, ...hrs. or ....min.

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.
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

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1 - 17 , 1959

22. I HEREBY CERTIFY, That I attended deceased from 19 to , 19
I last saw him 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:

	Date of onset
Head & chest injuries	
compound fracture	
left arm & right leg	

Other contributory causes of importance:
Called for at 2:10 pm

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) B. E. Hogan , M. D.
(Address) West Plains Mo

SUPPLIED

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.

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

S- 2494