

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE  
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1936

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

7257  
 Do not use this space.

1. PLACE OF DEATH  
 (a) County Monroe Registration District No. 582  
 (b) Township \_\_\_\_\_ Primary Registration District No. 4344 Registered No. 7  
 (c) City Paris (d) Street No. ONE Merry 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. 3 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME NELLIE J. MANUEL  
 (a) Residence, No. Monroe Co. Mo. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF George Manuel  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JULY 25, 1881  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
57 8 12

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home  
 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) MONROE CO., Mo.  
 13. NAME GEORGE HASLON  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) KY.  
 15. MAIDEN NAME SUSAN PATERSON.  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N.Y.

17. INFORMANT GEORGE MANUEL (ADDRESS) R.#2, MADISON, Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE MT. AIDY Church DATE MAY 9<sup>TH</sup>, 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Speed & Blakely Paris Mo.  
 20. FILED 3-8 1939 F. A. Barnett M.O. Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 7<sup>th</sup>, 1939.  
 22. I HEREBY CERTIFY, That I attended deceased from Mar 5, 1939, to Mar 7, 1939  
 I last saw her alive on Mar 7, 1939 Death is said to have occurred on the date stated above, at 9:15 P. m.  
 The principal cause of death and related causes of importance were as follows:  
Acute Bright's Disease Date of onset Don't know  
 Other contributory causes of importance: \_\_\_\_\_  
 Name of operation None Date of \_\_\_\_\_  
 What test confirmed diagnosis Clinical Was there an autopsy? No

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) M. C. McMurphy, M. D.  
 (Address) Paris, Mo.

120

RECEIVED

District Health Officer No. 10

District File Number 10-39-364

Date Filed MAR 15 1939

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 E. H. Agnew

Licensed Embalmer No. 4000

P. O. Address Paris 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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

7257  
Do not use this space.

1. PLACE OF DEATH

(a) County Monroe Registration District No. 582  
(b) Township ..... Primary Registration District No. 4344 Registered No. ....  
(c) City Paris (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

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-7 1939

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

22. I HEREBY CERTIFY, That I attended deceased from 19... to ... 19...  
I last saw h... alive on ... 19... Death is said to have occurred on the date stated above, at ... m.

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

The principal cause of death and related causes of importance were as follows:  
acute Brights Disease  
acute nephritis  
with uremia

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.  
57 8 12

Date of onset  
n.m.o.  
Other contributory causes of importance:  
130

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

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

MOTHER 15. MAIDEN NAME

MOTHER 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

24. Was disease or injury in any way related to occupation of deceased? .....  
If so, specify  
(Signed) M. C. Mc Murray, M. D.  
(Address) Paris, Mo.

SUPPLEMENTARY

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.

Local Registrar.

