

AUG 14 1939

Registration District No. 175

Primary Registration District No. 6020-A

Registrar's No. 56

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Bonne Terre, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ Specify whether

In this community 8 mo. 23 days
years, months, or days

3. (a) PRINT FULL NAME Argue Lowell Manning

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if

7. Birth date of deceased October 27 1938
(Month) (Day) (Year)

8. AGE: Years 0 Months 8 Days 23 If less than one day
hr. _____ min. _____

9. Birthplace Bonne Terre Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Argue Lowell Manning

13. Birthplace Dongolia Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Balthrop

15. Birthplace Nashville Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Argue Lowell Manning

(b) Address 128 Church St. Bonne Terre, Mo

17. (a) Burial (b) Date thereof July 23, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation B. J. Cemetery

18. (a) Signature of funeral director Benham Fed Co

(b) Address 313 Benham St. Bonne Terre, Mo

19. (a) July 22, 1939 (b) N. W. Hawkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town Bonne Terre
(If outside city or town limits, write "RURAL")

(d) Street No. 128 Church
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22
year 1939 hour 3 minute A. M.

21. I hereby certify that I attended the deceased from By Inquest
deceased, 19____, to _____, 19____;

that I last saw him alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Strangulation Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Strangulation

(b) Date of occurrence 7-22-1939 12 A.M.

(c) Where did injury occur? at home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Bonne Terre Mo

While at work? _____ (e) Means of injury h

28. Signature Geo Diemer Coroner
(M. D. or other)

Address FLAT RIVER MO Date signed 7-22-39

182-
111

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

C. J. Claywell

Licensed Embalmer No.

3706

P. O. Address

Crown Point

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete 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

26704
Do not use this space.

1. PLACE OF DEATH *A. Francois*
 (a) County *A. Francois* Registration District No. *775*
 (b) Township Primary Registration District No. *6020A* Registered No. *36*
 (c) City *Bonne Terre* (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 *Arque Howell 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 *s* (write the word)

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.
8 *23*

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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *7-22-1939*

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.
 The principal cause of death and related causes of importance were as follows:
Stipulation
Sudden onset with death and caused by lymphatic with enlarged thymus gland.
 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) *Gas. Diemer* _____
 (Address) *Flat River* _____

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH IN plain terms, so that it may be properly classified. - Exact statement of OCCUPATION is very important.

S-26704

1939