

SEP 6 1939

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

29089  
Do not use this space.

1. PLACE OF DEATH

(a) County Franklin. Registration District No. 297  
 (b) Township Washington. Primary Registration District No. 3016 Registered No. 75  
 (c) City Washington. (d) Street No. St. Francis 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 20 yrs. X mos. X ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

521 Maude B. Mankopf.  
 (a) Residence, No. 300 W. 5th St., Washington, Mo. 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED  
BOOKKEEPER  
 (OR) WIFE OF Dr. Bert E. Mankopf.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 30th, 1877.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
61 7 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House-wife.  
 9. Industry or business in which work was done, as saw mill, bank, etc. X  
 10. Date deceased last worked at this occupation (month and year) July 1939. 11. Total time (years) spent in this occupation X

12. BIRTHPLACE (CITY OR TOWN) Memphis,  
 (STATE OR COUNTRY) Missouri.

FATHER 13. NAME Ben F. Bourn,

14. BIRTHPLACE (CITY OR TOWN) Memphis,  
 (STATE OR COUNTRY) Missouri.

MOTHER 15. MAIDEN NAME Alice Calvin.

16. BIRTHPLACE (CITY OR TOWN) Memphis,  
 (STATE OR COUNTRY) Missouri.

17. INFORMANT Dr. Bert E. Mankopf.  
 (ADDRESS) Washington, Missouri.

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Washington, Mo. DATE Aug. 5th, 1939

19. FUNERAL DIRECTOR (NAME) Nieburg & Vitt, Inc.,  
 (ADDRESS) Washington, Missouri.

20. FILED Aug. 3 - 1939 A. A. May  
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 2nd, 1939.

22. I HEREBY CERTIFY, That I attended deceased from 7/3, 1939, to 8/2, 1939  
 I last saw her alive on 8/2, 1939. Death is said to have occurred on the date stated above, at 1:35 P.M.  
 The principal cause of death and related causes of importance were as follows:

Cardiac Failure  
Pericarditis  
Vincent's type of Pulmonary infection (Interstitial Pneumonia)  
General debility  
 Date of onset 7/24/39  
6/18/39

Name of operation..... Date of.....  
 What test confirmed diagnosis? X-ray + Lab 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) Michael S. Heffick, M. D.

(Address) 3208 Locust, Harrison, 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.

NOV 9 1948

**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 A. P. Bierberg  
Licensed Embalmer No. 2387  
P. O. Address Washington

**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.**