

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 13 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14152

State File No. _____
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County ANDREW JEFFERSON TOWNSHIP
(b) City or town SAVANNAH RURAL
(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 ENTIRE LIFE
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Andrew
(c) City or town Savannah RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. _____ LINCOLN
JEFFERSON TOWNSHIP
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME JOSEPH MANN 56r
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 4 day 8
year 1940 hour _____ minute _____ P. M.
21. I hereby certify that I attended the deceased from April 8
1940 to April 8, 1940
that I last saw him alive on April 8, 1940
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWER
6. (b) Name of husband or wife SARAH ANN 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased JULY 18 1860
(Month) (Day) (Year)

Immediate cause of death Myocardial infarction
Duration _____

8. AGE: Years 79 Months 8 Days 20
If less than one day _____ hr. _____ min.

Due to _____
Due to _____

9. Birthplace ANDREW CO MO
(City, town, or county) (State or foreign country)

Other conditions None
(Include pregnancy within 3 months of death)

10. Usual occupation CARPENTER + FARMING

11. Industry or business _____

Major findings: _____
Of operations _____
Of autopsy None
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
12. Name THOMAS MANN
13. Birthplace UNKNOWN OHIO
(City, town, or county) (State or foreign country)
14. Maiden name M. OLIVE KERSEY
15. Birthplace UNKNOWN KY
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

16. (a) Informant's own signature George F. Mann
(b) Address Lewistown Mont.

While at work? _____ (Specify type of place) (e) Means of injury _____

17. (a) _____ (b) Date thereof 4-11-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation AMAZONIA

18. (a) Signature of funeral director J. Fred Tubman
(b) Address Savannah Mo

23. Signature J. P. Hilday (M. D. or other) _____
Address Savannah Mo Date signed 4-9-40

19. (a) 4-10-40 (b) J. W. Holcomb
(Date received local registrar) (Registrar's signature)

RECEIVED
District Health Officer No. 11,
District File Number 540-665
Date Filed MAY 7 1940

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

J. Fred Terhune, Registered Apprentice No. 1279
working under my personal supervision.

Signed J. Fred Terhune
Licensed Embalmer No. 1279
P. O. Address Savannah

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.