

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.

State File No. \_\_\_\_\_

Registration District No. 095

Primary Registration District No. 5791

Registrar's No. 5

1. PLACE OF DEATH:  
 (a) County Montgomery W. Co. Mo.  
 (b) City or town Waverly  
 (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) 2  
 (d) Length of stay: In hospital or institution 54 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County \_\_\_\_\_  
 (c) City or town Waverly (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME James Edward Mansfield  
 8. (b) If veteran name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month April day 15  
 year 1940 hour 1 minute 30 M.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

21. I hereby certify that I attended the deceased from December 1, 1940 to April 15, 1940, that I last saw him alive on April 12, 1940 and that death occurred on the date and hour stated above.

7. Birth date of deceased Aug 28 1888  
 (Month) (Day) (Year)

Immediate cause of death Cancer of Esophagus  
 Duration 10 mo.

8. AGE: Years 51 Months 7 Days 16  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

9. Birthplace Millwood Mo  
 (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

12. Name James Mansfield  
 13. Birthplace Ireland  
 (City, town or county) (State or foreign country)

14. Maiden name Mary Tallin St John  
 15. Birthplace Ireland  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Dr. James Mansfield  
 (b) Address Waverly Mo

17. (a) Burial (b) Date thereof 4-16-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director W. B. B. B.  
 (b) Address Waverly Mo  
 19. (a) April 16, 1940 (b) Mrs. Mike McDemore  
 (Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
 23. Signature J. Mansfield (M. D. or other)  
 Address Waverly Mo Date signed 4/15/40

PHYSICIAN  
 \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**