

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

15721

MAY 20 1940

662

Registration District No. \_\_\_\_\_

Primary Registration District No. 5879

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

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Perry  
(b) City or town 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 9  
In this community 65 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Katherine Mangels 534  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Herman Mangels 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 19 1856  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
82 8 16 hr. min.

9. Birthplace Hanover Gormany  
(City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business \_\_\_\_\_  
12. Name John Katt  
13. Birthplace Hanover Gormany  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Theo M. Mangels  
(b) Address Farrer Mo.

17. (a) Burial (b) Date thereof April 18 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Farrer Mo.

18. (a) Signature of funeral director Langston  
(b) Address Perryville Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Perry  
(c) City or town Rural  
(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. 65 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5  
year 1940 hour 10 minute 30 A. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1940 at \_\_\_\_\_, 1940  
that I last saw him alive on 4-2-40, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy?  
Cerebral Hemorrhage

Duration

3 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions none  
(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) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? none  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

978 While at work? \_\_\_\_\_ (Specify type of place)  
(a) Means of injury \_\_\_\_\_

23. Signature F. P. Pallock (M. D. or other)

Address Farrer Mo. Date signed 4-6-40

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.

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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 *W. Wallace of Perry*.....

Licensed Embalmer No. *4027*.....

P. O. Address *Perryville, 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. 662

Primary Registration District No. 5879

Registrar's No. ....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Perry  
(b) City or town Bertrams T.P.  
(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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Katherina Mangela

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

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced und

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased July-19-1836  
(Month) (Day) (Year)

8. AGE: Years 82 Months 8 Days 16 If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) W.H. Bernoth  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month apr day 5  
year 1910 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 G.F. Patrick (M. D. or other) \_\_\_\_\_

Address Truhna Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-15724