

1940 JUN 15 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **19289**

Registration District No. **713**

Primary Registration District No. **5942**

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

1. PLACE OF DEATH:  
(a) County Pulaski  
(b) City or town "Rural" Cullen  
(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 Life  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Joseph Callaway Manes 520  
3. (b) If veteran, name war No 3. (c) Social Security No. NO

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced divorced  
6. (b) Name of husband or wife Hilma Manes 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov. 28 1886  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
53 5 4 hr. min.

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

10. Usual occupation Farmer

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

MOTHER FATHER { 12. Name Jacob Newton Manes  
18. Birthplace Pulaski Co.  
(City, town, or county) (State or foreign country)  
14. Maiden name Emiline Campbell  
15. Birthplace Pulaski Co.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Carl Anderson  
(b) Address Waynesville, Mo.

17. (a) Burial (b) Date thereof May 3, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bethlehem Cem.

18. (a) Signature of funeral director J. L. HOOPS & SONS.  
(b) Address Crocker, Mo.

19. (a) 5/6/40 (b) C. G. Talbot  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Pulaski  
(c) City or town "Rural" Cullen Twn. Ship  
(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 May day 2  
year 1940 hour 1 minute 30 A. M.

21. I hereby certify that I attended the deceased from 4/25, 1940, to 5/2, 1940 that I last saw him alive on 4/25, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Valvular Heart Disease

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? \_\_\_\_\_

23. Signature C. G. Talbot (M. D. or other) MD  
Address Waynesville Date signed 5/24/40

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

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.

**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.....

**RECEIVED**

working under my personal supervision,  
**District Health Officer No. 8,**

**District File Number: 240 705**

**Date Filed 6/24/0**

....., Registered Apprentice No.....

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.**