

7-39
X23159

NOV 21 1940

STANDARD CERTIFICATE OF DEATH

State File No. 36187

Registration District No. 914

Primary Registration District No. 6235

Registrar's No.

1. PLACE OF DEATH:

(a) County: Ray
(b) City or town: Hardin Grape Grove
(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: 2
(Specify whether years, months or days)
In this community: all his life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Ray
(c) City or town: Hardin
(If outside city or town limits, write "RURAL")
(d) Street No.: 10 Mi North Hardin
(If rural, give location)
(e) If foreign born, how long in U. S. A.?: _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day Aug year 1940 hour 8 minute P. M.
21. I hereby certify that I attended the deceased from Mar 5, 1940 to Nov 7, 1940
that I last saw him alive on Nov 7, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Paralysis
Right Side - affecting
arterial sclerosis

Duration 4 days
10 yrs
PHYSICIAN
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME

John F. MANKING

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive deceased
18 (Day) 1857 (Year)

7. Birth date of deceased: 8 (Month) 18 (Day) 1857 (Year)

8. AGE:

Years 83 Months 2 Days 19
If less than one day hr. min.

9. Birthplace

Ray Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

Farmer

12. Name

Frederic Manking

13. Birthplace

Germany
(City, town, or county) (State or foreign country)

14. Maiden name

Anna Pepper

15. Birthplace

Germany
(City, town, or county) (State or foreign country)

16. (a) Informant

Mrs. Joe Manking

(b) Address

Springton Mo

17. (a)

Burial (b) Date thereof: Nov-9-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

Wakenda Cem

18. (a) Signature of funeral director

Jno W Knipschiel

(b) Address

Hardin Mo

19. (a)

Mrs. Miss Manking
(Date received local registrar) (Registrar's signature)

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

Marion Brinn (M. D. or other)

Address Hardin, Mo.

Date signed 11/9/40

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

82H

RECEIVED
District Health Officer No. 8,
District File Number 11-14-40
Date Filed

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 me

Registered Apprentice No.

working under my personal supervision.

Signed John W. Kuspich

Licensed Embalmer No. 2789

P. O. Address Hardin 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36189

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 914

Primary Registration District No. 6235-

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Ray
(b) City or town Stape Grove 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

John F Mankiey

(b) If veteran, name war _____

(c) Social Security No. _____

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____

(Month) (Day) (Year)

8. AGE:

Years 83 Months 2 Days 19

If less than one day _____ hr. _____ 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) _____
(Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____
(Date received local registrar)

(b) _____

(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 Nov day 7
year 1990 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis
Hemiplegia affecting
right side
arterio-sclerosis

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Barbara H. H. H. H.
12/14/90
MD, Gen.

Duration

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? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTAL

