

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.

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 36660

Registration District No. 996

Primary Registration District No. 4542

Registrar's No. 42

1. PLACE OF DEATH:
 (a) County Webster
 (b) City or town Marshfield
 (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 x 20
 In this community 28 years
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME Johanna Mahn
 8. (b) If veteran, name war x 8. (c) Social Security No. x

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced
 6. (b) Name of husband or wife John Mahn 6. (c) Age of husband or wife if alive x years
 7. Birth date of deceased February 11 - 1871
 (Month) (Day) (Year)

8. AGE: Years 69 Months 7 Days 15 If less than one day x hr. x min.

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

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER
 12. Name John Janssen
 13. Birthplace Germany
 (City, town, or county) (State or foreign country)

14. Maiden name Gretka
 15. Birthplace Germany
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Frank Andrews

(b) Address Marshfield, Missouri

17. (a) Burial (b) Date thereof Sept 26-1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshfield, Mo.

18. (a) Signature of funeral director for Haney

(b) Address Marshfield, Mo.

19. (a) Oct 15-40 (b) Elyse H. Hefner
 (Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 24
 year 1940 hour 10 minute p. M.

21. I hereby certify that I attended the deceased from Sept 1 - 40, to Sept 24 1940
 that I last saw him alive on _____ 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Left Kidney

Due to _____

Due to _____

Other conditions 46
 (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 220

(c) Where did injury occur? 220
 (City or town) (County) (State)

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

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

23. Signature W. F. Behrman (M. D. or other) _____

Address Haney Date Oct 25 1940

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 6;

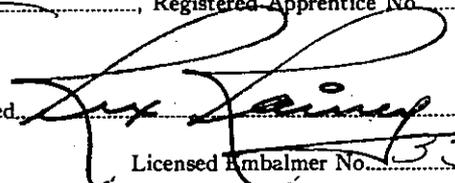
District File Number: 1140-2822

Date Filed: NOV 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 _____

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed:  _____

Licensed Embalmer No. 3312

P. O. Address: Marshfield, 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.