

No. 2
11-10-39
-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **10312**

APR 9 1941 136
Registration District No. **136**

Primary Registration District No. **5204**

Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Carroll**
(b) City or town **Rural Miami Sup**
(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

8. (a) PRINT FULL NAME **Ronald Dee Mann**
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: **Apr 8 1940** (Month) (Day) (Year)

8. AGE: Years **0** Months **11** Days **20** If less than one day _____ hr. _____ min.

9. Birthplace **Miami Station Mo** (City, town, or county) (State or foreign country)
10. Usual occupation **Infant**

11. Industry or business _____
12. Name **Oscar Mann**
13. Birthplace **Carroll Mo** (City, town, or county) (State or foreign country)
14. Maiden name **Marybelle Manning**
15. Birthplace **Dellmar Okla** (City, town, or county) (State or foreign country)

16. (a) Informant **Oscar Mann**
(b) Address **Miami Station Mo**
17. (a) **Burial** (b) Date thereof **3-29-41** (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Evergreen Cem**
18. (a) Signature of funeral director **Stanley**
(b) Address **Carrollton Mo**
19. (a) **March 29 41** (b) **Alta Henderson** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Carroll**
(c) City or town **Miami Station** (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 **Mar** day **28** year **1941** hour **4** minute **45** a.m.
21. I hereby certify that I attended the deceased from **Mar 28** 19**41** to **Mar 28** 19**41** and that death occurred on the date and hour stated above.

Immediate cause of death **Stroke**
Due to **Lobar**
Due to **pneumonia**
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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? _____
23. Signature **P. H. Smith** (Specify type of place) _____
Address **Carrollton Mo** (City or town) (County) (State) Date signed **Mar 29 41**

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

700

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed
11-8-71

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.