

FILED FEB 24 1942

Primary Registration District No. 4232

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Blue Springs, Missouri
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Leavenworth
(c) City or town Ft. Leavenworth, Kansas
(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.

3. (a) PRINT FULL NAME Boyd V. Mann

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Boyd V. Mann 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased December 30, 1912
(Month) (Day) (Year)

8. AGE: Years 28 Months 1 Days 10 If less than one day _____ hr. _____ min.

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

10. Usual occupation Second Lieutenant 127th

11. Industry or business Obsn. Sq. U. S. Army

12. Name Henry Boyd Mann

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

14. Maiden name Mabel Vaughn

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

16. (a) Informant's own signature U. S. Army

(b) Address Ft. Leavenworth, Kansas

17. (a) Removal (b) Date thereof 2-11-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leavenworth Kan

18. (a) Signature of funeral director Webb Funeral Home

(b) Address Blue Springs, Missouri

19. (a) 2-11-42 (b) W. A. Webb
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 10 year 42 hour 4 minute 32 P 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 _____ the date and hour stated above.

Immediate cause of death Coronary Artery Disease
and heart

Due to Angiogram Accident

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy See above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 2/10/42

(c) Where did injury occur? Room of go hrs
(City or town) (County) (State)

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

While at work? Yes (Specify type of place) (e) Means of injury Accident

28. Signature W. A. Webb (M.D. or other) _____
Address Kenn Date signed 2/11/42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Rev. 5-17-30 I 419311

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.

OCT 4 1943

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 R. B. [Signature]
Licensed Embalmer No. [Signature]
P. O. Address [Signature]

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.