

FILED FEB 9 1944

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

4055

Do not use this space.

1. PLACE OF DEATH

(a) County Randolph Registration District No. 294
 (b) Township Spring Creek Primary Registration District No. 3056 (Registered No. 2484)
 or Mobile
 (c) City Mobile (d) Street No. White Corners Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State) MO
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5/16/1869
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 8 11
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/27 1944
 22. I HEREBY CERTIFY, That I attended deceased from Feb 14 1943 to Jan 27 1944
 I last saw him alive on Jan 26 1944 Death is said to have occurred on the date stated above, at 11:32 m.
 The principal cause of death and related causes of importance were as follows:
Prostatic Neck Tumor Date of onset _____

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? suicide Date of injury Jan 29, 44
 Where did injury occur? at home (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Prostatic Neck Tumor
 Nature of injury suicide, by fall

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____

(Signed) John P. Allen, M. D.
 (Address) Mobile, Ala.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Randolph Co. Mo.

13. NAME John Manning

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Alabama

15. MAIDEN NAME Beale Vaughan

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) H. R. Manning
Mobile, Ala.

18. BURIAL, CREMATION, OR REMOVAL PLACE Land Prairie DATE Jan 30, 44

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Irma Nave
Madison, Mo.

20. FILED 1-30-44 Irma Nave
 Local Registrar.

1066 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. E.—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.

I X16605

RECEIVED

District Health Officer No. 10

District File Number

2-44-418

Date Filed

FEB 8 1944

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

Mrs. J. A. Thompson

Licensed Embalmer No.

2282

P. O. Address

Madison, 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.