

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**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

10460  
 Do not use this space.

FILED APR 10 1944

1. PLACE OF DEATH  
 (a) County BUCHANAN Registration District No. 8542  
 (b) Township \_\_\_\_\_ Primary Registration District No. 1001/000 Registered No. 277 977  
 (c) City ST. JOSEPH (d) Street No. 0 ST. JOSEPH 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 John Mankle  
 (a) Residence, No. \_\_\_\_\_ St.  New Market Iowa  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Cora Mankle  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-22-1866  
 7. AGE YEARS 77 MONTHS 5 DAYS 11 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 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  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not given Illinois  
 FATHER 13. NAME Jacob Mankle  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany  
 MOTHER 15. MAIDEN NAME Mary Jane Mankle?  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown  
 17. INFORMANT (ADDRESS) Son - John Mankle Jr. New Market Gravity Ia  
 18. BURIAL, CREMATION, OR REMOVAL PLACE New Market Ia DATE 3-16 1944  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hes. Walker Clarinda Iowa  
 20. FILED 3-16 1944 Rae Herzog Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar-16 1944  
 22. I HEREBY CERTIFY, That I attended deceased from March 4, 1944, to March 16, 1944  
 I last saw him alive on March 16, 1944. Death is said to have occurred on the date stated above, at 11:50 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Acute Encephalitis Date of onset 2-23-44  
 Other contributory causes of importance: gob  
 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? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify: \_\_\_\_\_  
 (Signed) Dr. H. Truman, M. D.  
 (Address) St. Joseph Mo

**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 Loren Dawson

John Licensed Embalmer No. 3148

P. O. Address Clarinda, Iowa

**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.**