

S. No. 2  
M-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27762  
Registrar's No. 658

FILED AUG 23 1944

Registration District No. 128

Primary Registration District No. 5465

39  
00

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

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Rural, N. Campbell Twp  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Greene County Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institutions 10 days (Specify whether  
stay)

In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Green

(c) City or town Rural, S. Campbell Twp  
(If outside city or town limits, write "RURAL")

(d) Street No. Route #1, Box 377, (2840 W. Lasalle)  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME EVE LAPERNE MANSKEP

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19  
year 1944 hour 3:00 minute \_\_\_\_\_ M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife NONE

6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased 8 - 12 - 1944  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from saw baby after death. Was seen by Dr Kelly before death 19\_\_\_\_; that I last saw \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Likely due to Cerebral hemorrhage

Duration \_\_\_\_\_

8. AGE: Years \_\_\_\_\_ Months X Days X If less than one day 8 hr. X min.

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

Due to Sudden labor and sudden expulsion from uterus

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

10. Usual occupation INFANT

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Ernest Manskep

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

14. Maiden name Lena Alexander

15. Birthplace Dallas Co. Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Lena Manskep

(b) Address Springfield Mo

17. (a) Buried (b) Date thereof Aug 14 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant View

18. (a) Signature of funeral director J. J. Jones

(b) Address Springfield Mo

19. (a) 8-14-44 (b) J. W. Handley  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place) (Means of injury)

23. Signature James J. Amos (M. D. or other) \_\_\_\_\_  
Address Springfield, Mo Date signed 8/14/44

**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.....

*Leonard B. Jones*

Licensed Embalmer No. 2508

P. O. Address... Buffalo, 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, fact should be so stated above.**