

FILED OCT 10 1944

3075

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County HOWELL

(b) City or town WEST PLAINS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
912 CASS AVE.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No. (Specify whether)

In this community 55 YEARS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County HOWELL 46

(c) City or town WEST PLAINS
(If outside city or town limits, write "RURAL")

(d) Street No. 912 CASS AVE
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM WALTER MANTZ

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 19, year 1944 hour 2: minute 15 A. M.

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife LILLIA BEAZLEY MANTZ

6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased _____
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 14, 1944 to Sept 19, 1944; that I last saw him alive on Sept 18, 1944; and that death occurred on the date and hour stated above.

8. AGE: Years 77 Months 9 Days 20 If less than one day _____ hr. _____ min.

Immediate cause of death Intestinal hemorrhage Duration 1 wk

9. Birthplace MARION, VA.
(City, town, or county) (State or foreign country)

10. Usual occupation INSURANCE AGENT

Other conditions Chronic Spondylitis (Include pregnancy within 3 months of death) 10 yr.

Major findings: General Arteriosclerosis

Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name BENJAMIN FRANKLIN MANTZ

13. Birthplace GRAYSON CO., VA.
(City, town, or county) (State or foreign country)

14. Maiden name ELIZ. JANE SEAYER

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

16. (a) Informant MRS. LILLIAN MANTZ

(b) Address WEST PLAINS, Mo.

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

(c) Place: OAK LAWN CEM. WEST PLAINS, Mo.

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? _____

18. (a) Signature of funeral director Hal Stombough

(b) Address WEST PLAINS, Mo.

19. 30-44 (b) Stombough
(Data received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

Means of injury _____

Signature L. E. Bohrer (M. D. or other) MD

Address West Plains, Mo. Date signed 9-22-44

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5.

District File Number. 1044498

Date Filed 10-9-44

FEB 18 1946

MAY 21 1954

JAN 21 1946

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

Hal Thouburg

Licensed Embalmer No.

3A08

P. O. Address

West Plains, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31043

Registration District No. 141

Primary Registration District No. 3025

Registrar's No. 77

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

1. PLACE OF DEATH:

(a) County Howell

(b) City or town West Plains
(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

3. (a) PRINT FULL NAME Walter M. Waterman

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Nov. 29 1866
(Month) (Day) (Year)

8. AGE: Years 27 Months 9 Days 20 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov 1944 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above, and that the immediate cause of death was Intestinal hemorrhage 1 wk. Duration _____

Due to Benign Ulcer of Duodenum

Due to _____

Other conditions Chronic spondylitis 10 yr.
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: general arteriosclerosis

Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature E. C. Bohrer M.D. (M.D. or other) _____

Address West Plains, Mo. Date signed 10-23-44

