

S. No. 2
M-5-43
5-17-39
1 X38671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43802
Registrar's No. 27

FILED APR 7 1947
Registration District No. 377

Primary Registration District No. 3074

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Sikeston
(c) Name of hospital or institution:
846 Matthews Ave.
(d) Length of stay: In hospital or institution _____
In this community 40 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Scott
(c) City or town Sikeston
(d) Street No. 846 Matthews
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ELMER F. MANGRUM
3. (b) If veteran, name war _____ 3. (c) Social Security No. 497-09-9904

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 18 year 1946 hour 12 minute 45 P.M.
21. I hereby certify that I attended the deceased from 6-15-46 to 8-25 1946
that I last saw him alive on 9-18-46 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Sarah Mangrum 6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased 03 20 1883 (Month) (Day) (Year)

Immediate cause of death Carcinoma of lower Esophagus & cardiac stomach
Due to _____

8. AGE: Years 63 Months 5 Days 18 If less than one day _____ hr. _____ min.

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations 46
Of autopsy _____

9. Birthplace Umana Ill (City, town, or county) (State or foreign country)
10. Usual occupation Laborer
11. Industry or business _____
12. Name Hawell Mangrum
13. Birthplace Ill (City, town, or county) (State or foreign country)
14. Maiden name Mary Prolander
15. Birthplace Ill (City, town, or county) (State or foreign country)

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 _____

16. (a) Informant Sarah Mangrum
(b) Address Sikeston, Mo
17. (a) Burial (b) Date thereof 9/20/46 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sikeston, Mo
18. (a) Signature of funeral director Taylor Funeral Home
(b) Address Sikeston, Mo
19. (a) 3-29-47 (b) Wm. G. Henry (Date received local registrar) (Registrar's signature)

23. Signature E. D. Urban (M. D. or other) M.D.
Address Sikeston, Mo Date signed 11-15-46

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

42607

RECEIVED

District Health Office No. 2

District File Number 442-46

4-3-47

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 *W. Bluff*

Licensed Embalmer No. *4399*

P. O. Address *Poplar Bluff*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.