No. 2
12-45
17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 579

Registration District No. 72 Primary Registration District No. 6289 Registrar's No. 710

1. PLACE OF DEATH:

(a) County Clay Gallatin Twp

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

(c) Name of hospital or institution: At the Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether
In this community 9 mo. 9 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ~~XXXX~~ Mo. (b) County Clay 24

(c) City or town Minneville Mo 9
(If outside city or town limits, write "RURAL")

(d) Street No. Village 9
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME DAVID JOE MANKINS

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife None

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

7. Birth date of deceased April (Month) 14 (Day) 1946 (Year)

8. AGE: Years (0) Months 9 Days 9 If less than one day ✓ hr. ✓ min.

9. Birthplace General Hosp. #1 K.C. Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

FATHER
12. Name Lenonard D. Mankins
13. Birthplace Shawnee Oklahoma
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Eva Lee Smith
15. Birthplace Strickln Arkansaw
(City, town, or county) (State or foreign country)

16. (a) Informant Lenonard D. Mankins
(b) Address Minneville, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/47 (Month) (Day) (Year)
(c) Place: burial or cremation Minneville Cemetery

18. (a) Signature of funeral director Morton Smiths Fr. Home
(b) Address 832 Armour Rd., North Kans. City Mo.

19. (a) Jan 24 1947 (Date received local registrar) Beulah Kitchen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 23rd
year 1947 hour 10:30 minute a. M.

21. I hereby certify that I attended the deceased from Coroners Case, to ____, 19__;
that I last saw h____ alive on ____, 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia ✓ | Duration

Due to Coroners Case

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Coroners Case

Of autopsy

PHYSICIAN
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) Pneumonia

(b) Date of occurrence Jan. 23rd 1947

(c) Where did injury occur? Minneville Clay Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Cat Home Minneville, Mo.
(Specify type of place)

While at work? (e) Means of injury

23. Signature P. W. Prather Coroner 3 (M. D. or other)

Address Excelsior Springs, Mo Date signed 1-23-47

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 1-31-47

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 Chester D. Fleming, Registered Apprentice No. 447, working under my personal supervision.

Signed

Licensed Embalmer No. 3928

P. O. Address 832 Armour NKC

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.

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Fiel

Registration District No. 72 Primary Registration District No. 5289 Registrar's No. 10

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Minneville (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)

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

3. (a) PRINT FULL NAME David J. Mankins

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) 14 (Day) 1946 (Year)

8. AGE: Years 0 Months 9 Days 9 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Month Day 23 year 1947 hour minute M.

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

Immediate cause of death Bronchial Pneumonia

Due to

Due to Coroner Case

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 107

Duration

PHYSICIAN

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature R. W. Prather Coroner (M. D. or other)

Address Ex. Spgs. Mo. Date signed

SUPPLEMENTARY

S-579