

No. 2
6-14-41
5-17-39
X-29484

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED JUN 3 1947

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

19872

State File No.

Registrar's No. *84 24*

Registration District No. *343*

Primary Registration District No. *6154*

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

1. PLACE OF DEATH:

(a) County: *Stoddard*
(b) City or town: *Essex Route 2*
(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: *Mo.* (b) County: *Stoddard*
(c) City or town: *Essex Route 2 / 103*
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country?.....
If yes, name country.....

3. (a) PRINT FULL NAME: *HOMER ORVAL MANSTER*

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex: *male* 5. Color or race: *white* 6. (a) Single, widowed, married, divorced.....

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

7. Birth date of deceased: *April 9 1947*
(Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

12. Name: *Willard Manster*

13. Birthplace: *Advance, Mo.*
(City, town, or county) (State or foreign country)

14. Maiden name: *Paul Anderson*

15. Birthplace: *Mountain View, Ark.*
(City, town, or county) (State or foreign country)

16. (a) Informant: *Mrs. Willard Manster*
(b) Address: *Essex, Mo. Route 2*

17. (a) (Burial, ~~cremation~~, or removal) (b) Date thereof: *May 29-47*
(Month) (Day) (Year)

(c) Place: burial or cremation: *Advance, Mo.*

18. (a) Signature of funeral director: *Kate Hervey*
(b) Address: *Essex, Mo.*

19. (a) *May 29-47* (Date received local registrar) (b) *Kate Hervey* (Registrar's signature) *356*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: *April* day: *29*
year: *1947* hour: *7:30* minute: *A.M.*

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

Immediate cause of death: *accidental smothering*

Due to.....

Due to.....

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.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): *accidental smothering*

(b) Date of occurrence: *April 29 1947 / 103*

(c) Where did injury occur: *Essex Route 2 Stoddard, Mo.*
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? *at home*

While at work?..... (Specify type of place)
(e) Means of injury: *3*

23. Signature: *St. Alex one* (Mr. Dr. or other) *Cor*
Address: *Dexter* Date signed: *4-29-47*

RECEIVED
District Health Office No. 2,
District File Number 647-298
Date Filed 6-2-47

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

Registration District No. 342 Primary Registration District No. 6154

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Rural
(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 Homer O Mansker
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color w 6. (a) Single, widowed, married, divorced s
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased April 9 (month) (day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ 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 (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation Advanced

18. (a) Signature of _____ Director _____ (b) Address _____

19. (a) 4-27-47 (b) Kate Hawley (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1947 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

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.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY 29

S-19872