

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14908

FILED JUN 3 1955

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 59 PRIMARY REG. DIST. NO. 4097 Registrar's No. 63

1. PLACE OF DEATH  
a. COUNTY Cass  
b. CITY (If outside corporate limits, write RURAL and give town) Harrisonville  
c. LENGTH OF STAY (in this place) Group  
d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Harrisonville Hosp.  
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE Missouri b. COUNTY Henry  
c. CITY OR TOWN Clinton  
d. Is Residence within limits of a city or incorporated town? Yes  No   
STREET ADDRESS (If rural, give location) 409 E. Sandrumer

3. NAME OF DECEASED (Type or Print)  
a. (First) JESSE b. (Middle) CLAUDE c. (Last) THANN  
4. DATE OF DEATH (Month) (Day) (Year) MAY 24 1955

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 8. DATE OF BIRTH Dec 6 1889 9. AGE (In years last birthday) 65 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Retail Shoes 10b. KIND OF BUSINESS OR INDUSTRY Shoery 11. BIRTHPLACE (City and State or Foreign Country) Appleton City Mo. 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Robt. Mann 13b. MOTHER'S MAIDEN NAME Unknown 14. NAME OF HUSBAND OR WIFE Sarah Lillian Mann

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. yes 17. INFORMANT'S SIGNATURE OR NAME Sarah Lillian Mann ADDRESS Clinton Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) CHRONIC CHLORALDEPHRITIS MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 6 wks

ANTECEDENT CAUSES DUE TO (b) 592X  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (c)  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death. TOXIC MYOCARDIOPATHY

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES  NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAY 14, 1955 to MAY 24, 1955, that I last saw the deceased alive on MAY 24, 1955, and that death occurred at 8:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE J.C. Moody (Degree or title) M.D. 23b. ADDRESS HARRISONVILLE Mo. 23c. DATE SIGNED 5-24-55

24a. BURIAL, CREMATION, REMOVAL (Specify) burial 24b. DATE 5/27/55 24c. NAME OF CEMETERY OR CREMATORY Engelwood Cem 24d. LOCATION (City, town, or county) (State) Clinton Mo.

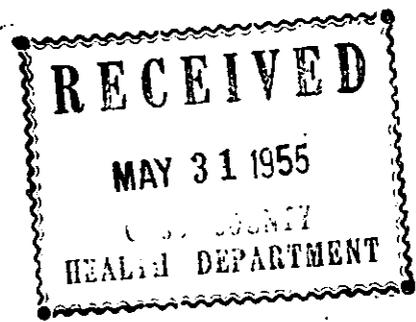
DATE REC'D BY LOCAL REG. May 24, 1955 REGISTRAR'S SIGNATURE Dora Barnard 457-10 25. FUNERAL DIRECTOR'S SIGNATURE F.L. Schaberg ADDRESS Clinton Mo.

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

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Box 498  
Clinton, Mo.

JUN 8 1955



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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed F. L. Schaberg

Licensed Embalmer No. \_\_\_\_\_  
P. O. Address Clinton

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.