

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19942

State File No. \_\_\_\_\_

No. 300  
10.48

FILED JUN 25 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 4 PRIMARY REG. DIST. NO. 4014 Registrar's No. 61

|   |  |  |                                   |
|---|--|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Atchison</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Holt</u> |                                   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fairfax</u> |  | c. LENGTH OF STAY (in this place) <u>2 wks.</u>  | c. CITY OR TOWN <u>Mound City</u> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fairfax Community Hosp.</u>                      |  | e. STREET ADDRESS (If rural, give location) <u>6490 7 Mi. NW of Mound City</u>   |                                   |

|                                     |                         |             |                       |   |
|-------------------------------------|-------------------------|-------------|-----------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>MAUDE</u> | b. (Middle) | c. (Last) <u>MANN</u> | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>June 10, 1957</u> |
|-------------------------------------|-------------------------|-------------|-----------------------|---|

|                      |                               |   |                                       |   |   |   |
|----------------------|-------------------------------|---|---------------------------------------|---|---|---|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Mar. 18, 1884</u> | 9. AGE (In years last birthday) <u>73</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 15 HRS. Hours _____ Min. _____ |
|----------------------|-------------------------------|---|---------------------------------------|---|---|---|

|  |  |   |   |
|--|--|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>In the home</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>Fairfax, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
|--|--|---|---|

|  |  |  |
|--|--|--|
| 13a. FATHER'S NAME <u>Daniel Bower</u> | 13b. MOTHER'S MAIDEN NAME <u>Nancy McKay</u> | 14. NAME OF HUSBAND OR WIFE <u>John Mann</u> |
|--|--|--|

|   |  |  |               |
|---|--|--|---------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>John Mann, Mound City, Missouri</u> | ADDRESS _____ |
|---|--|--|---------------|

|   |   |  |   |
|---|---|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hr</u> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>   |  |   |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |   |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
|------------------------|----------------------------------|--|

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

|  |  |                           |
|--|--|---------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR |
|--|--|---------------------------|

22. I hereby certify that I attended the deceased from JANI, 1954, to June 10, 1957, that I last saw the deceased alive on June 10, 1957, and that death occurred at 8:30 AM, from the causes and on the date stated above.

|   |                                    |                                 |
|---|------------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <u>Isaac F. Swearing</u> | 23b. ADDRESS <u>M.A. Creps, Mo</u> | 23c. DATE SIGNED <u>6/10/57</u> |
|---|------------------------------------|---------------------------------|

|   |                            |  |  |
|---|----------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>6/12/1957</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>New Liberty Cem.</u> | 24d. LOCATION (City, town, or county) (State) <u>Holt County, Missouri</u> |
|---|----------------------------|--|--|

|   |   |   |                               |
|---|---|---|-------------------------------|
| DATE REC'D BY LOCAL REG. <u>June 17, 1957</u> | REGISTRAR'S SIGNATURE <u>Merwin H. Schaefer</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac F. Swearing</u> | ADDRESS <u>Mound City, Mo</u> |
|---|---|---|-------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

12 4104 4

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 *James H. Crawford*

Licensed Embalmer No. *479*

P. O. Address *Mound City*

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.

*James H. Crawford*