DEPARTMENT OF COMMERCE
BUREAU OF [illegible] NOV 21 1940

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 36187

Registration District No. 914 — Primary Registration District No. 6235 — Registrar's No.

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

**1. PLACE OF DEATH:**
(a) County Ray
(b) City or town Hardin Grape Grove (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 2 (Specify whether years, months or days) In this community All his life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Missouri (b) County Ray
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. 10 Mi North Hardin (If rural, give location) Mo
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME. John F. MANKING
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 Widowed
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive, deceased years
7. Birth date of deceased 8 (Month) 18 (Day) 1857 (Year)

8. AGE: Years 83 | Months 2 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Ray Co Mo (City, town, or county) ____ (State or foreign country)
10. Usual occupation Farmer
11. Industry or business Farmer
MOTHER FATHER
12. Name Frederick Mankin
13. Birthplace Germany (City, town, or county) ____ (State or foreign country)
14. Maiden name Emma Pepper
15. Birthplace ____ (City, town, or county) Germany (State or foreign country)
16. (a) Informant Mrs. Joe Manking
(b) Address Lexington Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-9-1940 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Wakenda Cem
18. (a) Signature of funeral director Jno W Knipschild
(b) Address Hardin Mo
19. (a) ____ (Date received local registrar) (b) Mrs Josiah Manson (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 7 day ~~Aug~~ Nov year 1940 hour 8 minute 0 A. M.
21. I hereby certify that I attended the deceased from Nov 5, 1940, to Nov 7, 1940, that I last saw h~~im~~er alive on Nov 7, 1940, and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Paralysis | 4 days |
| Hypostatic Congestion affecting Right Side — | |
| Due to Arterio sclerosis | 10 yrs |
| 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? ____ While at work? ____ (Specify type of place) (e) Means of injury ____

23. Signature Marvin Grimes (M. D. or other) ____
Address Hardin, Mo. Date signed 11/9/40

(Licensed Embalmer's Statement on Reverse Side)

825

RECEIVED
District Health Officer No. 8,
District File Number 11-14-45
Date Filed

## 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 me

..... Registered Apprentice No. .....

working under my personal supervision.

Signed John W. Kruschild

Licensed Embalmer No. 2789

P. O. Address Hardin Mo

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

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

No. 2B
-2-21-40
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BUREAU OF THE CENSUS

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State File No. 36187

Registration District No. 914 — Primary Registration District No. 6235 — Registrar's No.

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

**1. PLACE OF DEATH:**

(a) County Ray
(b) ~~City or town~~ State Grove T. P.
(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 years, months or days)
In this community

**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) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME John T 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 wid
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 83 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
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, 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 by local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov day 7
year 1940 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.

| | Duration |
|---|---|
| Immediate cause of death Paralysis | |
| Due Hemiplegia affecting | |
| Due right side | |
| Due arterio sclerosis | |
| Other conditions (Include pregnancy within 3 months of death) | |

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations
Of autopsy

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

SUPPLEMENTARY