

APR 19 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

11380

Do not use this space.

1. PLACE OF DEATH

(a) County Laurens Registration District No. 47.5  
 (b) Township Spring Hill Primary Registration District No. 5639  
 (c) City Verona, Mo. (d) Street No. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 522 J. B. Mangas  
Verona, Mo. Route St.   
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR, OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Mangas  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 20, 1858  
 7. AGE YEARS 80 MONTHS 2 DAYS 0 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Ohio (STATE OR COUNTRY) 1

FATHER 13. NAME John Mangas  
 14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) 9

MOTHER 15. MAIDEN NAME Unknown  
 16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) 9

17. INFORMANT Mary Mangas (ADDRESS) Verona, Mo. Route

18. BURIAL, CREMATION, OR REMOVAL Catholic Cemetery, Verona DATE Feb. 22, 1939

19. FUNERAL DIRECTOR (NAME) Oscar R. Marsh, Mgr. (ADDRESS) Aurora General Home, Aurora, Mo.

20. FILED 4/5 39 A. J. Kudog Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 19 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1939, to Feb. 19, 1939  
 I last saw him... alive on Feb. 19, 1939. Death is said to have occurred on the date stated above, at P. A. m.  
 The principal cause of death and related causes of importance were as follows:

Cardiac Failure

Date of onset

Other contributory causes of importance:

Cerebral Apoplexy  
Arterio-sclerosis  
Chronic bronchitis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) P. W. Marshall, M. D.  
Verona, Missouri.

426 (Address)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 6]

District File Number 6-39-774

Date Filed 4-10-39

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, Meyer

, or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed Osca Marsh

Licensed Embalmer No. 3812

P.O. Address Curran, Mo.

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH

11380  
Do not use this space.

1. PLACE OF DEATH

(a) County Lawrence Registration District No. 475  
(b) Township Spring River Primary Registration District No. 5638  
(c) City ..... (d) Street No. .... St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Jacob Bernard Mangas St.   
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m  
(write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 - 19 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19...  
I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
80 2 0

Date of onset

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) .....  
11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation ..... Date of.....

What test confirmed diagnosis? ..... Was there an autopsy?.....

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury....., 19.....  
Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS)

Manner of injury.....

Nature of injury.....

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ..... 19.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify (Signed) R. W. Marshall, M. D.

(Address) Brookwood

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 5/15 1939 A. J. Rudig Local Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

