

Registration District No. **907**

Primary Registration District No. **45748**

Registrar's No. **25**

1. PLACE OF DEATH:

(a) County **WRIGHT**
(b) City or town **MANSEFIELD**
(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**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **WRIGHT**
(c) City or town **MANSEFIELD**
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **24**
year **1940** hour **5** minute **50 A.M.**

21. I hereby certify that I attended the deceased from **Nov 1**, 19**40** to **Dec 24**, 19**40**
and that I last saw **her** alive on **Dec 24**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Breast of female**
Duration **19**

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? **832**

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **J. P. Turner** (M. D. or other) **1**
Address **Manassas** Date signed **Dec 24-40**

3. (a) PRINT FULL NAME **NORA E. YANCEY**

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

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOW**

6. (b) Name of husband or wife **HEKMAN C YANCEY** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **NOV 13 1885**
(Month) (Day) (Year)

8. AGE: Years **55** Months **1** Days **11** If less than one day _____ hr. _____ min.

9. Birthplace **THAYER MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE**

11. Industry or business _____

12. Name **J. W. MOYAN**

13. Birthplace **NOT KNOWN**
(City, town, or county) (State or foreign country)

14. Maiden name **MARTHA MCSAUSTON**

15. Birthplace **CRAB ORCHARD SPGS KENTUCKY**
(City, town, or county) (State or foreign country)

16. (a) Informant **Abel Yancey**

(b) Address **Manassas Mo.**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **DEC 27 1940**
(Month) (Day) (Year)

(c) Place: burial or cremation **LAMAR Cem**

18. (a) Signature of funeral director **J. A. Steffe**

(b) Address **Manassas Mo.**

19. (a) **Dec. 24, 1940** (Date received local registrar) (b) **J. M. D. Short** (Registrar's signature)

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

578
5
RECEIVED

District Health Officer No. 6,

District File Number 141-74

Date Filed JAN 9 1941

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 F. A. Stoffe

Licensed Embalmer No. 3221

P. O. Address Manfield Ind

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 44237
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 907

Primary Registration District No. 4548

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

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Manassfield
(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 _____ (Specify whether _____)
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) If foreign born, how long in U.S.A.? _____ years.

3. (a) PRINT FULL NAME Nora E. Gancy

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

4. Sex F 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 55 Months 1 Days 11 If less than one day _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (c) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24 year 1940 hour _____ minute _____ 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 Carcinoma of pelvic organs
Due to Primary seat would was Cervix

Other conditions _____ (Include pregnancy within 3 months of death) 48

Major findings: Of operations _____

Of autopsy _____

Duration _____
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) _____ (e) Means of injury _____

23. Signature J. J. Fuson (M. D. or other) _____
Address Manassfield Mo Date signed 2-20-41

SUPPLEMENTARY

