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

42308

PLACE OF DEATH

County: Reynds.

Township: Webb — Registration District No. 1108 — File No. ____

or Village: X — Primary Registration District No. 5983 — Registered No. 20

or City: X (No. ____ St.; ____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Ann. Eliza. Mann.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female.

COLOR OR RACE: White.

~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word): Married & Seporated

DATE OF BIRTH: ~~Nov. 29 1910~~ (Month) (Day) (Year)

AGE: 39 yrs. 11 mos. 13 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work: House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): Farming

BIRTHPLACE (City or town, State or foreign country): Webb Twp. P.O. Piedmont Mo

PARENTS

NAME OF FATHER: T. N. Dinkins

BIRTHPLACE OF FATHER (City or town, State or foreign country): Missouri

MAIDEN NAME OF MOTHER: Myra L. Farris.

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Webb Twp.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): G. A. Farris. J.P. acting Coroner

(ADDRESS): Redford. Mo.

Filed: Dec 18, 1916 G. A. Farris. J.P. acting Coroner REGISTRAR

H. L. Meadows,

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov. 29, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased ~~from~~ Nov. 29, 1915, to ____, 191__, ~~that I last saw h__ alive on~~ ____, 191__, and that death occurred, on the date stated above, at 9 a.m. 30

The CAUSE OF DEATH* was as follows:

Murdered by. J. S. Mann. at His Hands. by Using a rock Beating Her Head. Bursting her head in 2 or 3 Places (Duration) and ___ yrs. Cutting ___ mos. ___ ds.

Contributory (Secondary): her Throat Clear down to Spinal Column (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) G. A. Farris. Coroner J.P.

____, 191__ (Address) Redford. Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE ~~(For Hospitals, Institutions, Transients, or Recent Residents)~~

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? Murdered.

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Buffington Cemetary

DATE OF BURIAL: Dec. 1, 1915

UNDERTAKER: C. S. Deisel

ADDRESS: Piedmont Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____ _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, 1____
(Month) (Day) (Year)

AGE

_____yrs. _____mos. _____ds.

If LESS than 1 day, _____hrs. or _____min.?

OCCUPATION

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, 191____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____ that I last saw h____ alive on _____, 191____ and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____(Duration)_____yrs._____mos._____ds.

Contributory _____
(SECONDARY)

_____(Duration)_____yrs._____mos._____ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death_____yrs._____mos._____ds. In the State_____yrs._____mos._____ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS

The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

cause of death.—Name, first, CAUSING DEATH (the primary affection to time and causation), using always the