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

Do not use this space.

8687

R 20 1927

1. PLACE OF DEATH
County Johnson
Township Montreal
City Warrensburg (No. ..... St. ..... Ward)

Registration District No. 431
Primary Registration District No. 5593

File No. .....
Registered No. .....

2. FULL NAME Ethel Manis

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 12, 1888.

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
38	10	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Kansas

PARENTS

10. NAME OF FATHER Will Saunders
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Villa Bray
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown.

14. INFORMANT John Manis
(Address) Warrensburg, ? Mo

15. FILED 3/17 1927 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 15, 1927

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1927, to March 15, 1927 that I last saw her alive on March 15, 1927, and that death occurred, on the date stated above, at 7 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(1) Puerperal Hemorrhage
144A
144B (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) (1) Placenta Previa
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

0 DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) [signature], M. D
, 19 (Address) Knob Noster Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Warrensburg Cem, DATE OF BURIAL Mar, 17 1927

20. UNDERTAKER Sweeney- Gore Phillips ADDRESS Warrensburg

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