

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

Do not use this space.
10980

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City, **St. Louis**, (No. **St. Johns Hospital**, St. **2660** Ward)

2. FULL NAME

David Franklin Manning, Jr.
 (a) Residence, No. **#519 Hamilton Ave. S.** Ward.....
 (Usual place of abode) (If decedent give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male.** 4. COLOR OR RACE **White.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Oct 3rd, 1896**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
30. 5. 14.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Salesman.**
 (b) General nature of industry, business, or establishment in which employed (or employer) **Park - Davis Drug, Co.**
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Marshall, Mo.**

10. NAME OF FATHER **D. J. Manning, Sr.**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Bara, Mo.**

12. MAIDEN NAME OF MOTHER **Margaret L. Mackey**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Starksville, Mo.**

14. INFORMANT **D. J. Manning Sr.**
 (Address) **Marshall, Mo.**

15. FILED 19 **Mar 6 1927**
 REGISTRAR

3. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Mar 17 1927**

17. I HEREBY CERTIFY, That I attended decedent from **Mar 15 1927** to **Mar 17 1927** that I last saw him alive on **Mar 17 1927** and that death occurred, on the date stated above, at **3300**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
1141 1927
1927
Subdural hemorrhage

CONTRIBUTORY (SECONDARY) **Pericardial embolus**
 (duration) yrs. mos. da. **4 da.**

18. WHOSE DISEASE CONTRACTED NOT AT PLACE OF DEATH? **Yes**

DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF **Mar 15**

WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) **[Signature]** M. D.
 (Address) **[Address]**

*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 **Marshall, Mo.** DATE OF BURIAL **3-18-27**

20. UNDERTAKER **L. R. Rupton** ADDRESS **[Address]**

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.

