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

Do not use this space.

3615

1. PLACE OF DEATH

County ..... Registration District No. 7801 File No. .....

Township ..... Primary Registration District No. 207 Registered No. 2149

City St. Louis (No. City Hospital St. ..... Ward)

2. FULL NAME William Manning

(a) Residence. No. Eric House St., 25 Ward ..... (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 1 1871

7. AGE: Years 56 | Months 10 | Days 13. | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer.
(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) Kentucky

PARENTS
10. NAME OF FATHER John T. Manning
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not Known
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Hospital Information

14. INFORMANT E. Rosan
(Address) City Hospital

15. FILED FEB 27 1928, 19.. Max C. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 14 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec 9, 1927, to June 14, 1928 that I last saw him alive on June 14, 1928, and that death occurred, on the date stated above, at 9 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 31

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Henry C. Westerman, M. D

1/16, 1928 (Address) City Hospital

*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: Washington U. | DATE OF BURIAL: 2/7 1928

20. UNDERTAKER: W. Richter | ADDRESS: 3500 Rutger

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.

Training.