

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

Do not use this space.

17316

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Lean Primary Registration District No. 1002
 City Kansas City (No. K.C. General Hosp.) St. _____ Ward _____

File No. _____
 Registered No. 289

2. FULL NAME

Manning, Tom

(a) Residence. No. 22nd & Drury St. 12 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. 12 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 10 1881

7. AGE: YEARS 46 MONTHS 9 DAYS 14 IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Electrician
 (b) General nature of industry, business, or establishment in which employed (or employer) Long Building
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) England

10. NAME OF FATHER

Thomas

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ireland

12. MAIDEN NAME OF MOTHER

Mary McLean

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ireland

14.

INFORMANT Emma J Manning
 (Address) 22nd & Drury

15.

FILED 5/24 28 m.m. Crowe REGISTRAR
asar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-24 1928

17. I HEREBY CERTIFY, That I attended deceased from 5-17, 1928, to 5-24, 1928 that I last saw him alive on 5-24, 1928, and that death occurred, on the date stated above, at 4:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Epidemic Cerebro spinal meningitis

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Edm & Lab Findings

(Signed) P. O. Deere, M. D.
5-24 1928 (Address) Subt K.C. Gene Hosp.

*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

DATE OF BURIAL

St Marys

5/26 28

20. UNDERTAKER

ADDRESS

John W. Wagner

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**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Jackson Registration District No. 399 File No. _____
 Township _____ Primary Registration District No. 1002 Registered No. 2289
 City St. Louis (No. _____) St. _____ Ward _____

2. FULL NAME Manning, Tom
 (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 m **4. COLOR OR RACE** w **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** m
 (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day,** _____ hrs. or _____ min.

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

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

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT _____ (Address) _____

15. FILED 5/23 1928 M. M. Browne REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-24 1928

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

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) _____, M. D.
 _____, 19____ (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 _____ **DATE OF BURIAL** _____ 19____

20. UNDERTAKER _____ **ADDRESS** St. Louis

SUPPLEMENTARY

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

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-17316