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

Do not use this space.

39152

1. PLACE OF DEATH
36 County Franklin
5 Township
6 City St-Clair (No. ..... St. ..... Ward)

Registration District No. 294
Primary Registration District No. 4128
File No.
Registered No. 60

2. FULL NAME Rose Mary Manion
(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.

JAN 23 1932

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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-1-1932

7. AGE — YEARS — MONTHS — DAYS 22 — If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) St-Clair Mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Robt. Manion
11. BIRTHPLACE OF FATHER (CITY OR TOWN) St-Clair Mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Dorothy Lack
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St-Clair Mo
(STATE OR COUNTRY)

14. INFORMANT Robt. Manion
(Address) St-Clair Mo

15. FILED 12/24, 1932 W. E. Kitchell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-23 1932

17. I HEREBY CERTIFY, That I attended deceased from 12/10, 1932, to 12-23-, 1932 that I last saw her alive on 12-23-, 1932, and that death occurred, on the date stated above, at 6 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho Pneumonia
11A
19 7A
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Influenza
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) W. E. Kitchell, M. D
12/24, 1932 (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 Greenwood — DATE OF BURIAL 19

20. UNDERTAKER Cosey & Co — ADDRESS St Clair —