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.

SEP 26 1933

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

Do not use this space.

27619

1. PLACE OF DEATH

96 County St. Louis — Registration District No. 1123 — File No.

Township Carondelet — Primary Registration District No. 62480 — Registered No. 264

City Koch (No. Koch Hospital St. Ward)

2. FULL NAME MANNING, ROSE

(a) Residence, No. 3517 Pine ST. L. Mo. 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
FEMALE	WHITE	MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 12 1906

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	26	7	27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

FATHER

13. NAME Clyde Eugene Sanders

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER

15. MAIDEN NAME Carrie Collins

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Koch Hospital Records

18. BURIAL, CREMATION, OR REMOVAL

PLACE St. Mathews Cem. DATE Aug 10 1933

19. UNDERTAKER (ADDRESS) J. H. Gibbons & Co. 2842 Meramec St.

20. FILED Aug 10 1933 L. C. Obrock M.D. L.A. Registrar.

MEDICAL CERTIFICATE OF DEATH

2

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 9 1933, 19

22. I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1931, 19, to Aug. 9 1933, 19

I last saw her alive on 8/9/33, 19 Death is said to have occurred on the date stated above, at 1:15 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary tuberculosis	1-1-30
23 B	
30	

Other contributory causes of importance:

Tuberculosis of Kidneys	Unknown

Name of operation No Date of

What test confirmed diagnosis? Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? No Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Joseph T. Maher, M. D.

(Address) Koch Hospital,