

WHILE LIVING USE UNDERNO BLACK INK—MAKE 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.

Registration District No. 784 Primary Registration District No. 115 Registrar's No. 157

1. PLACE OF DEATH: <sup>1940</sup>  
(a) County St. Louis  
(b) City or town University City, Mo.  
(c) Name of hospital or institution: 6510 Bartmer Ave., m  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME James J. Mannion  
3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Agnes Mannion 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec. 23, 1874

8. AGE: Years 65 Months 0 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Ireland (City, town, or county) (State or foreign country)

10. Usual occupation Retired bricklayer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William Mannion

13. Birthplace Ireland (City, town, or county) (State or foreign country)

14. Maiden name Mary Crosby

15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Jane Mannion

(b) Address 6510 Bartmer Ave.,

17. (a) burial (b) Date thereof Jan. 24/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Jas. W. Clark

(b) Address 1125 Hodiamont Ave.

19. (a) JAN 22 1940 (b) R. M. [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County St. Louis  
(c) City or town University City, Mo.  
(d) Street No. 6510 Bartmer Ave.,  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan. day 20  
year 1940 hour 10. minute 00 P. M.

21. I hereby certify that I attended the deceased from Jan 10, 1940 to Jan 10, 1940  
that I last saw him alive on Jan 10, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration 1 mo.  
Due to Chronic Myocarditis

Other conditions Sinistery  
(Include pregnancy within 3 months of death)

Major findings: 93c  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address 3700 Washington Date signed Jan 22, 1940

PHYSICIAN  
Underline the cause to which death should be charged statistically.

O.P.  
Dr. Otto-Hampton

3220 Washington

49th St. Newark Pa 07102

#153 Stensid. Hy 0449 R.  
Pa. 8502

1-3-PM

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Registered Apprentice No. ....

working under my personal supervision.

Signed *[Signature]*  
Licensed Embalmer No. 3226

P. O. Address 1125 Hodiament Ave.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, above space should be left blank.