No. 2
4-13-40
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 1 2 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34476

Registration District No. 599

Primary Registration District No. 1002

Registrar's No. 3992

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County: Jakcosn

(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether years, months or days)

In this community 26 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 430 Potter St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? No years.

3. (a) PRINT FULL NAME: Wm. G. MANNING

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: widowed

6. (b) Name of husband or wife: Ella Adkins

6. (c) Age of husband or wife if alive: dec. years

7. Birth date of deceased: 3/19/1861 (Month) (Day) (Year)

8. AGE: Years 79 Months 6 Days 26 If less than one day hr. min.

9. Birthplace: Carrollton, Mo. (City, town, or county) D (State or foreign country)

10. Usual occupation: Railroad man --Santa Fe

11. Industry or business: Railroad-Retired number of Yrs.

MOTHER FATHER

12. Name: No record

13. Birthplace: No record (City, town, or county) (State or foreign country)

14. Maiden name: No record

15. Birthplace: No record (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Edna Richardson

(b) Address: 430 Potter

17. (a) Mt. Washington (Burial, cremation or removal) (b) Date thereof: 10/25/40 (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Washington Cem.

18. (a) Signature of funeral director: John P. Sheil

(b) Address: 6606 Indep. Ave., K. C. Mo.

19. (a) 10-17-40 (Date received by local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day 10-15-40 year hour minute M.

21. I hereby certify that I attended the deceased from 11-38-P. 19 to 19; that I last saw alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage

Duration

Underlying causes: Cerebral or mental central lacerations of the brain

Fracture of the skull

Contributing causes: by fall

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: yes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): Accident

(b) Date of occurrence: 10-11-40

(c) Where did injury occur? K.C. (City or town) Mo (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (Specify nature of injury)

23. Signature: [illegible] (M. D. or other)

Address: K. C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.