

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **42567**
Registrar's No. **1043**Registration District No. **318**Primary Registration District No. **2001**

1. PLACE OF DEATH:

- (a) County **GREENE**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **CITY HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME

ROBERT E. MANWARING.

3. (b) If veteran, **None** name war. 3. (c) Social Security No. **499-07-8910**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Carolina M. Manwaring** 6. (c) Age of husband or wife if alive **25** years
7. Birth date of deceased **Feb 27 1907** (Month) (Day) (Year)

8. AGE: Years **33** Months **10** Days **3** If less than one day _____ hr. _____ min.

9. Birthplace **Unknown Illinois** (City, town, or county) (State or foreign country)
10. Usual occupation **Truck Driver**
11. Industry or business **Trucking**
12. Name **Robert E. Manwaring**
13. Birthplace **Unknown Illinois** (City, town, or county) (State or foreign country)
14. Maiden name **Nancy E. Fleming**
15. Birthplace **Unknown Illinois** (City, town, or county) (State or foreign country)

16. (a) Informant **Nancy E. Fleming Manwaring**
(b) Address **Springfield, Mo.**
17. (a) **Burial** (b) Date thereof **1-5-41** (Month) (Day) (Year)
(c) Place: burial or cremation **East day cemetery**
18. (a) Signature of funeral director **W. H. Lingner**
(b) Address **Springfield, Mo.**
19. (a) **1-5-41** (b) **M. E. Handley** (c) **Springfield, Mo.** (Date received local registrar) (Registrar's signature) (Address)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Mo.** (b) County **Greene**
(c) City or town **Springfield** (If outside city or town limits, write "RURAL")
(d) Street No. **624 Poplar** (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **30th** year **1940** hour **12** minute **30 P.** M.
21. I hereby certify that I attended the deceased from **Dec 27** 19**40**, to **Dec 30** 19**40**,
that I last saw him alive on **Dec 30** 19**40**,
and that death occurred on the date and hour stated above.

- Immediate cause of death **Acute Peritonitis**
Septicemia
Due to **Acute Purulent Appendicitis** 6 days.
Due to _____
Other conditions (Include pregnancy within 3 months of death) **12-1**
Major findings: **Acute (Ruptured) Peritonitis**
Of operations **Appendicitis**
Of autopsy **none**

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? _____
(Specify type of place)
(e) Means of injury _____
Signature **Newton H. Adams** (M. D. or other) _____
Address **Springfield, Mo.** Date signed **1-2-41**

(Licensed Embalmer - Statement on Reverse Side)

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

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

Roy A. Bunker

Licensed Embalmer No. *1763*

P. O. Address

Springfield, Mo.

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.