

0. 2  
4-41  
7-39  
X263  
34  
970

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

RECEIVED SEP 17 1941

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital #1  
(If not in hospital or institution, write the address or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
in this community 4 Days years, months or days)

3. (a) PRINT FULL NAME Joan Rae Manley  
3. (b) If veteran, name war No 3. (c) Social Security No. ---

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased August 22, 1941  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
4 Days 4 hr. min.

9. Birthplace St. Louis, Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business --

12. Name Earl Manley  
13. Birthplace Missouri (City, town, or county) (State or foreign country)

14. Maiden name Marie Tullock  
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Margaret Burke  
(b) Address City Hospital #1

17. (a) Cremation (b) Date thereof 8 28 41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Crematory  
18. (a) Signature of funeral director W. D. White  
(b) Address City Hospital No. 1

19. (a) AUG 27 1941 (Date received local registrar)  
(b) J. T. Bredbeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 000  
(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 913 e Montgomery (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 25 year 1941 hour 12:10 minute A. M.  
21. I hereby certify that I attended the deceased from August 22, 1941 to August 25, 1941; that I last saw her alive on August 25, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy Multiple infarctions

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) \_\_\_\_\_  
(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) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature W. D. Lawrence M. D. of other \_\_\_\_\_  
Address 1515 Lafayette Date signed 8/25/41

---

---

**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.**