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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 198

Primary Registration District No. 3011

Registrar's No. 73

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

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days
(Specify whether years, months or days)

In this community 11 days

3. (a) PRINT FULL NAME William A. Manley

3. (b) If veteran, name war World War

3. (c) Social Security No. -

4. Sex Male

5. Color or race white

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

6. (b) Name of husband or wife Olive Manley

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

7. Birth date of deceased Nov. 12th 1897
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>44</u>	<u>5</u>	<u>14</u>	<u>hr. min.</u>

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

10. Usual occupation Unknown

11. Industry or business -

MOTHER FATHER { 12. Name Collins D. Manley

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

14. Maiden name Hannah Raby

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

16. (a) Informant Hospital Records

(b) Address Excelsior Springs, Mo.

17. (a) Removal (b) Date thereof 4-26-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burlington, Kansas

18. (a) Signature of funeral director CLAUDE FRIEDLAND

(b) Address Excelsior Springs, Mo.

19. (a) 4-27-42 (b) Mrs. Edna Redman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 4808 East 6th
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26th
year 1942 hour 12 minute 40 A.M.

21. I hereby certify that I attended the deceased from April 15, 1942, to April 26, 1942;
that I last saw him alive on April 26, 1942;
and that death occurred on the date and hour stated above.

Immediate cause of death Abscess of lung

Duration 3 mo.

Due to Pneumonia

Due to -

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

PHYSICIAN

Major findings: Of operations Abscess

Of autopsy None

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? --

While at work -- (Specify type of place) (e) Means of injury --

23. Signature Jeremiah Last (M. D. or other)

Address JEREMIAH LAST, M.D. Date signed 4-26-42

(Licensed Embalmer's Statement on Reverse Side) Veterans Administration Excelsior Springs, Mo.

District Health Officer No. 8,

District File Number _____

Date Filed 5-7-42

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 Robert Ray

Licensed Embalmer No. 4182

P. O. Address Excelsior Spgs., 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.

Registration District No. 198

Primary Registration District No. 3011

Registrar's No.

1. PLACE OF DEATH

(a) County Clay

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

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

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

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William A. Manley

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Nov. 12, 1887
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>44</u>	<u>5</u>	<u>11</u>	<u>45</u> min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day _____
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Abscess of lung
Pneumonia - LOBAR

Due to _____

Due to Abscess of Lung, non-tubercular non-malignant. Pyogenic in type

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

Major findings:
Of operations _____

Of autopsy 108

ABJUDICATION DIVISION
JUN 19 1942

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)

(c) Means of injury _____

23. Signature Forrest G. Bell (M. D. or other) _____
Address FORREST G. BELL, M.D. Date signed _____
Chief Medical Officer
Veterans Administration, Excelsior Spgs. Mo.

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

MOTHER FATHER

SUPPLEMENTARY

APR 19 1942

ABJUDICATION DIVISION JUN 19 1942

108



15

3