

FILED MAY 10 1945
Registration District No. **12**

Primary Registration District No. **3034**

Registrar's No. **17**

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

4
2
1

1. PLACE OF DEATH:
 (a) County **Lafayette**
 (b) City or town **Higginville**
(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

3. (a) PRINT **Sarah Kathryn Manis**
 FULL NAME
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced, **widowed**
 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **April-2-1857**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	88	0	0	hr. _____ min. _____

9. Birthplace **Nera Warrensburg Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House keeper**

11. Industry or business _____

12. Name **William Parman**

13. Birthplace **Johnson County Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Bleivins**

15. Birthplace **Johnson County. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ms. Seaton**
 (b) Address **Higginville, Mo.**

17. (a) **Burial** (b) Date thereof **4-4-1945**
(Burial, cremation, or reburial) (Month) (Day) (Year)

(c) Place: burial or cremation **Johnson county**

18. (a) Signature of funeral director **W. B. ...**
 (b) Address **Higginville, Mo.**

19. (a) **4-4-1945** (b) **Dr. W. B. ...**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Lafayette**
 (c) City or town **Higginville**
(If outside city or town limits, write "RURAL")
 (d) Street No. **300 West Broadway**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **April** day **2-**
 year **45** hour **2** minute **15 p.** M.

21. I hereby certify that I attended the deceased from **Mar. 13** 19**45** to **Apr 2** 19**45**;
 that I last saw her alive on **Apr 1-** 19**45**;
 and that death occurred on the date and hour stated above.

Immediate cause of death—
Chronic Myocarditis - many years with stenosis -

Due to **Senile condition.**

Due to _____

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

Major findings:
 Of operations **12/18**
 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? _____

(e) Means of injury _____
(Specify type of place)

23. Signature **W. B. ...** (M. D. or other) **MD**
 Address **Higginville, Mo** Date signed **4/4/45**

Duration
many years
3 miles.

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

5/9/45

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. 539
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.