

S. No. 2
4-8-43
5-17-39
P I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24301

State File No. _____

Registration District No. 164

Primary Registration District No. 3032

Registrar's No. 64

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Warrensburg

(c) Name of hospital or institution:
Warrensburg Clinic 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days (Specify whether)

In this community 59 yrs (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson 51

(c) City or town Warrensburg Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. P. O. Box #20 Clinic 0
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Ona Walker Manis

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Walter Manis

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Mar 29 1886
(Month) (Day) (Year)

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

59 3 13 hr. min.

9. Birthplace Johnson Co Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation House Keeper

11. Industry or business Home

MOTHER FATHER { 12. Name Walker Crawford

13. Birthplace Not Known 9
(City, town, or county) (State or foreign country)

14. Maiden name Anna Brown

15. Birthplace Johnson Co Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Walter Manis

(b) Address RFD 2 Warrensburg Mo.

17. (a) Burial (b) Date thereof 7-15-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Sweeney Phillips

(b) Address Warrensburg Mo.

19. (a) July 14 1945 (b) Deala M. Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12 year 1945 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from July 10 1945 to July 12 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Diabetic Coma Duration 12 hr.

Due to neglected diabetes mellitus 10 years

Also - sustained of narcotics with abuse, generalist postmortem 10 days

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations U

Of autopsy _____

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? (c) Means of injury 0

23. Signature Deala M. Williams (M. D. or other) _____

Address Warrensburg Mo. Date signed 7/15/45

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

1001

FEB 17 1948

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

J. Earl Priest

Licensed Embalmer No. 3878

P. O. Address. Warrensburg, 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.