

U.S. No. 2
FORM-5-43
Rev. 5-17-39
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30582

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 766

FILED OCT 28 1945
Registration District No. 128

Primary Registration District No. 2000

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

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:
846 N. Grant /
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield 2
(If outside city or town limits, write "RURAL")

(d) Street No. 846 N. Grant 6
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Ella Manes

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife William Manes

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

7. Birth date of deceased October, 1, 1979
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>11</u>	<u>24</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name William A. York

{ 13. Birthplace UNK. UNK. 9
(City, town, or county) (State or foreign country)

{ 14. Maiden name Ellen Elizabeth (unknown)

{ 15. Birthplace UNK. UNK. 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elizabeth Robinson

(b) Address 846 N. Grant - Spfld., Mo.

17. (a) Burial (b) Date thereof Sept. 27, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address 534 St. Louis Street - Spfld., Mo.

19. (a) 9-27-45 (b) 5 W. H. Hensley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 25
year 1945 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept 23 to Sept 25, 1945
that I last saw h. alive on Sept 23, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis Caecum Duration 1 yr.

Due to _____

Due to _____

Other conditions 46 h
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

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? _____

While at work? _____ (Specify type of place)

By _____ Means of injury _____

23. Signature Max Fitch (M. D. or other) MD.

Address Springfield, Mo. Date signed 9-27-45

984

(Licensed Embalmer's Statement on Reverse Side)

DEC 6 195

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 Lewis G. Schaff

Licensed Embalmer No. 3802

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.

X