

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36664**

FILED DEC 42
Registration District No. **42**

Primary Registration District No. **5133**

Registrar's No. **1218**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **Rural - Marion Township**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Route #2 Easton, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **none**
(Specify whether
In this community **1 day**
years, months or days)

3. (a) PRINT FULL NAME **Infant McManus**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **no**

4. Sex **Female** 5. Color **White** 6. (a) Single, widowed, married, divorced **child**
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive. years
7. Birth date of deceased **November 9, 1945**
(Month) (Day) (Year)

8. AGE: Years **0** Months **0** Days **1** If less than one day hr. min.

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

10. Usual occupation **child**

11. Industry or business

12. Name **J. C. McManus**
13. Birthplace **Clarksdale, Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Kathleen Allgaier**
15. Birthplace **Easton, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **J. C. McManus**

(b) Address **Route #2, Easton, Mo.**

17. (a) **Burial** (b) Date thereof **11-10-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Hurlinger, Mo.**

18. (a) Signature of funeral director **Barry Funeral Home**

(b) Address **St. Joseph, Mo.**

19. (a) **Nov 17 1945** (b) **H. H. Littleback**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**
(c) City or town **Easton, Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **Route #2**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** Day **10**
year **1945** hour **5** minute **30 A** M.

21. I hereby certify that I attended the deceased from **11-9**, 19**45** to **11-10**, 19**45**;
that I last saw her alive on **11-9-45**, 19**45**;
and that death occurred on the date and hour stated above.

Immediate cause of death: **Myocardial insufficiency**
Due to **failure of closure of foremen orals**
Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations **1572**
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) (a) Means of injury **2**
23. Signature **Dr. H. H. Littleback** (M. D. or other)
Address **Stewartville, Mo.** Date signed **11-11-45**

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

Was not embalmed

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.