

Registration District No. **114**

Primary Registration District No. **4186**

1. PLACE OF DEATH:

(a) County **Franklin**
(b) City or town **Sullivan**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Residence
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community **Lifetime**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Franklin 36**
(c) City or town **Sullivan,**
(If outside city or town limits, write "RURAL") **1**
(d) Street No. _____
(If rural, give location) _____
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Jessie Manion

3. (b) If veteran name war **No** 3. (c) Social Security No. **498-16-8233**

4. Sex **Male 0** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Viola Ruth Cline Manion** 6. (c) Age of husband or wife if alive **XXX** years

7. Birth date of deceased **Feb 10 1892**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	54	9	29	hr. _____ min. _____

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

10. Usual occupation **Presser in cleaning shop**

11. Industry or business **Cleaning Shop**

12. Name **Thomas Manion**

13. Birthplace **Unknown Texas**
(City, town, or county) (State or foreign country)

14. Maiden name **Lucinda Hoffman Penn. /**
(City, town, or county) (State or foreign country)

15. Birthplace **Pittsburg Penn. /**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss June Manion**

(b) Address **Sullivan, Mo.**

17. (a) **Burial** (b) Date thereof **12/12/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **I. O. O. F. Sullivan, Mo.**

18. (a) Signature of funeral director **Wm. J. Puffer**

(b) Address **Sullivan, Mo.**

19. (a) **12-11-46** (b) **E. F. Altman**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** Day **9th** year **1946** hour **6** minute **45 a.** M.

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

Immediate cause of death **Compound fracture of skull**
Due to **gun shot.**

Due to _____
Other conditions **14 40**
(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) **Suicide**
(b) Date of occurrence **12/9/1946**
(c) Where did injury occur? **Sullivan Franklin Mo.**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home
While at work? **no** (Specify type of place) (e) Means of injury **gun shot**

23. Signature **E. F. Altman** (M.D. or other) **Coroner**
Address **Union Mo** Date signed **12/19/46**

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

38530

JAN 13 1947

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 12-16-46

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 Phos. P. Stoffer

Licensed Embalmer No. 2692

P. O. Address. Fuller, Md

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.