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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 25 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15400
Registrar's No. 3892

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Josephine Heitkamp Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution life
In this community life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 1751 Mississippi Avenue
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOHNNY RAY MANNING
3. (b) If veteran, name war nil 3. (c) Social Security No. none
4. Sex M 5. Color or race W. 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 8, 1947
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 4-11-47 day _____
year _____ hour 3 20 p.m. minute _____ M.
21. I hereby certify that I attended the deceased from birth
4-9-47, 19____, to _____, 19____;
that I last saw him alive on 4-11-47, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Wernemia
Duration 3 days

8. AGE: Years _____ Months _____ Days 3 If less than one day hr. _____ min. _____

Due to Congenital defects of Genito-urinary tract.

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

Due to Congenital malformation both legs from knee downward.
Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation Infant

Major findings: Blat. ill. feet etc. (groof left hamper) also present.
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Chester Ray Manning

13. Birthplace Walnut Ridge, Arkansas
(City, town or county) (State or foreign country)

14. Maiden name Rilla Mae Coose
(City, town or county) (State or foreign country)

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

16. (a) Informant Chester R. Manning
(b) Address 1751 Mississippi Avenue

17. (a) burial (b) Date thereof 4-12-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery
18. (a) Signature of funeral director A.W. McLaughlin
(b) Address 2301 Lafayette Avenue

19. (a) APR 14 1947 (b) G.F. Bredbeck
(Date received local registrar) (Registrar's signature)

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) If _____
(e) Means of injury _____
23. Signature John B. Ryan SMD (M. D. or other) _____
Address 9715 So 39th Date signed 4-12-47

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

MOTHER FATHER

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..... *L. P. Casper*

Licensed Embalmer No. *3633*

P. O. Address..... *2317 Lafayette*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. may
Registrar's No. 8895

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... ST. LOUIS
(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
In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Johnny R. Manning
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased April 8
(Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

13. (a) Signature of funeral director.....

(b) Address.....

19. (a) 4-14-1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... year 1947 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.
Immediate cause of death..... Duration

Due to.....

Due to.....

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

Major findings:
Of operations.....

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?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

MAY 9 1947

15400