FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUN 21 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18759

Registration District No. 42 | Primary Registration District No. 1000 | Registrar's No. 644

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St. Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mo. Meth. Hospital (If not in hospital or institution, write street, number or location)

(d) Length of stay: In hospital or institution: 14 days (Specify whether years, months or days)

In this community: 7 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Andrew 2

(c) City or town: Savannah 1 (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location) 1

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

If yes, name country

3. (a) PRINT FULL NAME: Joseph Crockett Manning

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Cloie Manning

6. (c) Age of husband or wife if alive: 61 years

7. Birth date of deceased: November (Month) 21 (Day) 1886 (Year)

8. AGE: Years 61 | Months 6 | Days 19 | If less than one day: hr. min.

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

10. Usual occupation: Physician & Surgeon

11. Industry or business: Medicine

FATHER 12. Name: M. K. Manning

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

MOTHER 14. Maiden name: Emma Gebhart

15. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country) 9

16. (a) Informant: Mrs. Cloie R. Manning

(b) Address: Savannah, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6/12/48 (Month) (Day) (Year)

(c) Place: burial or cremation: Ashland Cemetery

18. (a) Signature of funeral director: Heaton-Burman

(b) Address: St. Joseph, Mo.

19. (a) 6-14-48 (Date received local registrar) (b) E. E. Jenkins (Registrar's signature) 385

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10 year 1948 hour 8 minute 30 AM.

21. I hereby certify that I attended the deceased from May-27, 1948 to June-10, 1948 that I last saw him alive on June-9, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Haemorrhage	
Due to: Hypertension	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: yes	

PHYSICIAN — Underline the cause of 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) 0

While at work? (e) Means of injury

23. Signature: T. L. Howden (M. D. or other) MD

Address: 620 Francis Date signed: 6-11-48

St Joseph, Mo.

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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

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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 So 10th St Joseph, 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.