No. 2
47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30129

FILED SEP 16 1948

Registration District No. 56

Primary Registration District No. 2001

Registrar's No.

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St John 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital ~~or institution~~ 6 hrs (Specify whether
In this community I Week
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Okla (b) County Tulsa 999
(c) City or town Tulsa 34
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 2
If yes, name country

3. (a) PRINT FULL NAME John Alfred Manes
3. (b) If veteran, name war ~~no~~ Yes
3. (c) Social Security No. 525-28-2168
4. Sex M 0
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Cathryne Manes
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 30 (Day) 1905 (Year)

8. AGE: 43 Years | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Checotah (City, town, or county) Okla (State or foreign country) 1
10. Usual occupation Trucker
11. Industry or business Own Trck Line
FATHER
12. Name Harry Manes 9
13. Birthplace No Record (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Alice Brown 10
15. Birthplace No Record (City, town, or county) (State or foreign country) 1
16. (a) Informant Orin W Clifford
(b) Address Galena Kans
17. (a) Remaval (Burial, cremation, or removal) (b) Date thereof 9-9-48 (Month) (Day) (Year)
(c) Place: burial or cremation Galena, Kansas
18. (a) Signature of funeral director Potter Funeral Home
(b) Address Galena Kans
19. (a) 9-11-48 (Date received local registrar) (b) Ed James MD (Registrar's signature) 138

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 9
year 1948 hour 4 minute 15 p M.

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

	Duration
Immediate cause of death Diabetic Coma	24 hrs
Due to Diabetes mellitus	?
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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)
While at work? (e) Means of injury 0

23. Signature Paul H. Grubb (M. D. or other) M.D.
Address 611½ Main Galena, Kans Date signed 9-10-48

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

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

48-9-769

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 Haven E. Newman, Registered Apprentice No. ....., working under my personal supervision.

Signed Haven E. Newman

Licensed Embalmer No. 2067 Kans

P. O. Address Salina Kan

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.

No. 2B
I—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8 Oct

Registration District No. 156 Primary Registration District No. 2001 Registrar's No.

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Joplin
(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
years, months or days)

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

3. (a) PRINT FULL NAME John A. Maner

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased March 30 (Month) 1900 (Day) (Year)

8. AGE: Years 43 Months 5 Days 9 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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

18. (a) Signature of funeral director
(b) Address

19. (a) 9-11-48 (Date received local registrar) (b) Edw Jaynes (Registrar's signature) by Dalton Thompson

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Day 9
year 1948 hour minute M.

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

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Immediate cause of death	
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Due to	
Other conditions (Include pregnancy within 3 months of death)	

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Of autopsy

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(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)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

5-30129