

FILED JAN 19 1949

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3005

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital		e. STREET ADDRESS (If rural, give location) 5400 Arsenal Street	
3. NAME OF DECEASED (Type or Print) James		a. (First) James b. (Middle) A c. (Last) Manning	
4. DATE OF DEATH (Month) (Day) (Year) Jan 2 1949		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) Single	
8. DATE OF BIRTH 1881		9. AGE (In years last birthday) 67	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Missouri	
13a. FATHER'S NAME James Manning		13b. MOTHER'S MAIDEN NAME Marcella Dean	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Sister Mary Manning		ADDRESS Los Angeles Calif.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia		II. OTHER SIGNIFICANT CONDITIONS		5 days	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES			
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) abscess			
		DUE TO (c)			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 1, 1945, to Jan 2, 1949, that I last saw the deceased alive on Jan 2, 1949, and that death occurred at 5 a.m., from the causes and on the date stated above.

23a. SIGNATURE <i>S. Hopstetter M.D.</i>		23b. ADDRESS 5400 Arsenal		23c. DATE SIGNED 1-3-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan 4 1949		24c. NAME OF CEMETERY OR CREMATORY Calvary	
24d. LOCATION (City, town, or county) St. Louis		24e. (State) Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Cullen & Kelly	
DATE REC'D BY LOCAL REG. JAN 3 1949		REGISTRAR'S SIGNATURE <i>[Signature]</i>		ADDRESS 4386 Lindell St. Louis	

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

James A. Lammer
.....
Licensed Embalmer No. *4162*
.....
P. O. Address *St. Louis*
.....

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.