

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

21399

State File No. _____
 5878

FILED JUL 15 1949

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

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Boon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Boon		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
c. LENGTH OF STAY (in this place) 1		d. STREET ADDRESS (If rural, give location) 3702 Finney Ave	
3. NAME OF DECEASED (Type or Print) a. (First) Abree b. (Middle) Manning c. (Last) Manning			
4. DATE OF DEATH (Month) (Day) (Year) July 3 1949			

5. SEX Female	6. COLOR OR RACE 3 Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 17 1920	9. AGE (In years last birthday) 24	IF UNDER 1 YEAR Months 1 Days 17	IF UNDER 2 yrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maids		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Dennis Grant	13b. MOTHER'S MAIDEN NAME Josephine Huff	14. NAME OF HUSBAND OR WIFE John R. Manning
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 343-20-9062	17. INFORMANT'S SIGNATURE OR NAME Abree ADDRESS _____

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) Heat Exhaustion rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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) Boon Missouri
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? Stair

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **2:30 P** m., from the causes and on the date stated above. **Abree**

23a. SIGNATURE (Degree or title) Chas. P. ...	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 7/6/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE JUL 5 1949	24c. NAME OF CEMETERY OR CREMATORY Cook County, Chicago Ill

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE J. B. Hasater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Boon 000
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 _____

Henry C Williams

Student Embalmer No. 306

working under my personal supervision.

Henry C Williams
Signed _____
Student Embalmer

Signed *Edward A Flynn*

Licensed Embalmer No. 14444

P. O. Address 4548th Papp

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.

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