

FILED SEP 1 1949

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 26285

BIRTH NO. _____		REG. DIST. NO. <u>47</u>		PRIMARY REG. DIST. NO. <u>3008</u>		Registrar's No. <u>280</u>	
1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Andrew</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton 2</u>		c. LENGTH OF STAY (in this place) <u>4M. 2 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mexico 2</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>419 E. Breckenridge</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>JACOB</u>		b. (Middle) _____		c. (Last) <u>MANNS</u>	
4. DATE OF DEATH		(Month) <u>Aug</u>		(Day) <u>21</u>		(Year) <u>1949</u>	
5. SEX <u>Male 2</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed 2</u>	8. DATE OF BIRTH <u>? ? 1872</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>?</u> Days <u>?</u>	IF UNDER 24 HRS. Hours <u>?</u> Min. <u>?</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. Rev</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Mexico, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Do Man Mann</u>		13b. MOTHER'S MAIDEN NAME <u>unk</u>		14. NAME OF HUSBAND OR WIFE <u>unk</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT'S SIGNATURE OR NAME <u>State Hospital Records</u>		ADDRESS <u>Fulton</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senile Psychosis</u>				INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>304 X</u>	
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 <u>31 March</u> 1949, to <u>21 Aug</u> 1949, that I last saw the deceased alive on <u>21 Aug</u> , 1949, and that death occurred at <u>6 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>G.S. Waraich</u>				(Degree or title) <u>M.D.U</u>		23b. ADDRESS <u>Fulton, Mo.</u>	
23c. DATE SIGNED <u>21 Aug, 49</u>							
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Aug 21-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>OK</u>		24d. LOCATION (City, town, or county) (State) <u>Chicago Ill.</u>	
DATE REC'D BY LOCAL REG. <u>Aug 21-1949</u>		REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>		426		25. FUNERAL DIRECTOR'S SIGNATURE <u>Frank R. Parker (Chicago)</u>	
						ADDRESS _____	

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 23 1949

RECEIVED
AUG 29 1949
District Health Officer No. 9
District File Number

OCT 4 1949

SEP 28 1949

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ^{will be} ~~was~~ embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Stuart P. Parker

Licensed Embalmer No. 2900

P. O. Address 16 N. 4th St. Chgo

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.