

FILED APR 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15190
State File No. _____
Registrar's No. 891

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis CLAYTON		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 2 1/2 yrs		d. STREET ADDRESS (If rural, give location) 3863A Cottage Ave	
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Louis County Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) BRIDGET b. (Middle) c. (Last) MANNION	4. DATE OF DEATH (Month) (Day) (Year) APRIL 4 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed	8. DATE OF BIRTH Sept. 8 1857	9. AGE (In years last birthday) 93
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) Ireland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Michael Mannion	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Matthew Mannion
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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.	17. INFORMANT'S SIGNATURE OR NAME Mrs Sara Henley	ADDRESS 3863 Cottage Ave
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) FRACTURE, NECK OF RT FEMUR OPEN REDUCTION		1 WK
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. BRONCHOPNEUMONIA		22 5 DAYS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE Accident (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing Home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Overland St. Louis Mo.
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 3 27 50	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Bathroom door shut by wind-knocked dec. to floor.
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22. I hereby certify that I attended the deceased from 3-27-1950 to 4-4-1950, that I last saw the deceased alive on 4-4-1950, and that death occurred at 12:35 p.m., from the causes and on the date stated above.

23a. SIGNATURE Robert R. Parke (Degree or title) M.D.	23b. ADDRESS 601 Beechwood, Canyon	23c. DATE SIGNED 4/4/50
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24a. BURIAL CREMATION, REMOVAL (Specify) Burial	24b. DATE Apr. 7, 1950	24c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. 4-5-50	REGISTRAR'S SIGNATURE Herbert S. Dombey	FUNERAL DIRECTOR'S SIGNATURE J. Marshall	ADDRESS 4112 St. Louis
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

4000
47.6228

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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed William S. Sullivan

Licensed Embalmer No. 4899

P. O. Address St. Charles 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.