

FILED AUG 25 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 28508
7132

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Missouri		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2069	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis City Hospital #1				e. STREET ADDRESS (If rural, give location) 5412 Wabada Ave.			
3. NAME OF DECEASED (Type or Print) WILLIAM		a. (First)		b. (Middle)		c. (Last) MANWARING	
4. DATE OF DEATH AUGUST 10 1951		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, Married	
8. DATE OF BIRTH Dec. 24 1874		9. AGE (In years last birthday) 76		10. MONTHS 76		11. DAYS 76	
12. CITIZEN OF WHAT COUNTRY? Hannibal Mo.		13a. FATHER'S NAME Thomas Manwaring		13b. MOTHER'S MAIDEN NAME Martha Glasscock		14. NAME OF HUSBAND OR WIFE Sophie Manwaring	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. 486-16-4214		17. INFORMANT'S SIGNATURE OR NAME Sophie Manwaring		ADDRESS 5412 Wabada	
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) Cerebral Arteriosclerosis 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. Aspiration Pneumonia			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 334X		20. AUTOPSY? YES ☐ NO ☐			
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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 7-21-51 , 19____, to 8-10-51 , 19____, that I last saw the deceased alive on 8-10-51 , 19____, and that death occurred at 5:05A m., from the causes and on the date stated above.							
23a. SIGNATURE William A. Ferguson M.D.				23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 8-10-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/13/51		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County	
DATE REC'D BY LOCAL REG. AUG 10 1951		REGISTRAR'S SIGNATURE J. Earl Smith		25. FUNERAL DIRECTOR'S SIGNATURE Sullivan Funeral Dir.		ADDRESS 2849N. Euclid	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Licensed Embalmer No. 3553

P. O. Address St. Louis 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.