

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 23982

FILED JUL 21 1952

BIRTH NO. REG. DIST. NO. 77 PRIMARY REG. DIST. NO. 3016 Registrar's No. 170

264  
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Cole		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Cole	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Jefferson City) c. LENGTH OF STAY (in this place) 5 yrs		c. CITY (If outside corporate limits, write RURAL and give OR TOWN Jefferson City) 0264	
d. FULL NAME OF HOSPITAL OR INSTITUTION 228 East Dunklin Street		d. STREET ADDRESS (If rural, give location) 228 East Dunklin Street	

3. NAME OF DECEASED a. (First) George b. (Middle) William c. (Last) Manes			4. DATE OF DEATH (Month) (Day) (Year) July 12 1952			
5. SEX 0 Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb-28-1890	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairyman		10b. KIND OF BUSINESS OR INDUSTRY Dairy		11. BIRTHPLACE (State or foreign country) Sedalia, Missouri 0		12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME William R. Manes		13b. MOTHER'S MAIDEN NAME Nannie Atkinson		14. NAME OF HUSBAND OR WIFE Rose Manes	
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. 481-03-9462		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Rose Manes, Jefferson City, Mo	

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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH  5 years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 332X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 June 3<sup>rd</sup> 1952, to July 12, 1952, that I last saw the deceased alive on June 12, 1952, and that death occurred at 4 P. M., from the causes and on the date stated above.

23a. SIGNATURE Henry V. Seckman Jr MD (Degree or title)		23b. ADDRESS 506 E. High St.		23c. DATE SIGNED July 14 52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July-15-52		24c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	
				24d. LOCATION (City, town, or county) (State) Jefferson City, Mo	

DATE REC'D BY LOCAL REG. July 15-1952		REGISTRAR'S SIGNATURE R.P. Harris MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS MR. Robert Gordon Jefferson City, Mo	
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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.....

working under my personal supervision.

Student Embalmer No.....

Signed *Shirley J. Gordon*

Signed.....  
Student Embalmer

Licensed Embalmer No. *1986*

P. O. Address *Jefferson City 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.