

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **8867**

**FILED MAR 30 1953**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 363

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Buchanan</u>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><u>St. Joseph</u>  |                                  | c. CITY (If outside corporate limits, write RURAL and give township)<br><u>St. Joseph Rural Washington</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Missouri Methodist Hospt.</u>  |                                  | d. STREET ADDRESS (If rural, give location)<br><u>Route 5, Sparta Road 0110</u>  |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>Pearl</u> b. (Middle) <u>H</u> c. (Last) <u>Manning</u>  |                                  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>Mar. 22, 1953</u>   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>   | 8. DATE OF BIRTH<br><u>Aug. 31, 1885</u>             |
| 9. AGE (In years last birthday)<br><u>67</u>   |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own home</u> |
| 11. BIRTHPLACE (City and State or Foreign Country)<br><u>Chillicothe, Mo.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13a. FATHER'S NAME<br><u>Joel Smith</u>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Tabetha Ball</u>   |  |
| 14. NAME OF HUSBAND OR WIFE<br><u>Cecil E. Manning</u>   |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  |
| 16. SOCIAL SECURITY NO.<br><u>None</u>   |                                  | 17. INFORMANT'S SIGNATURE OR NAME Mo. ADDRESS<br><u>Cecil E. Manning Rt. 5, St. Joseph</u>   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u><br>ANTECEDENT CAUSES<br><u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br><u>Conditions contributing to the death but not related to the disease or condition causing death.</u> |  |
| 19a. DATE OF OPERATION   |                                  | 19b. MAJOR FINDINGS OF OPERATION<br><u>331X</u>  |  |
| 20. AUTOPSY?<br>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) m.   |                                  | 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>3-6, 1953</u> , to <u>3-22, 1953</u> , that I last saw the deceased alive on <u>3-21, 1953</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above. |                                  |  |  |
| 23a. SIGNATURE<br><u>W. E. Garrison MD.</u> (Degree or title)  |                                  | 23b. ADDRESS<br><u>St. Joseph Mo</u>   |  |
| 23c. DATE SIGNED<br><u>3-23-53</u>   |                                  | 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  |
| 24b. DATE<br><u>Mar. 24, 53</u>  |                                  | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Memorial Park Cemo</u>  |  |
| 24d. LOCATION (City, town, or county) (State)<br><u>St. Joseph, Mo.</u>  |                                  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>Clark Funeral Home 120 Illinois Av</u>  |  |
| DATE REC'D BY LOCAL REG.<br><u>March 27, 1953</u>  |                                  | REGISTRAR'S SIGNATURE<br><u>Esther M. Allison</u>  |  |

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

(Licensed Embalmer's Statement on Reverse Side)

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 Emma Clark

Licensed Embalmer No. 4238

P. O. Address St Joseph 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.