

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25895**

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FILED JUL 25 1953

BIRTH NO. _____ REG. DIST. NO. **278** PRIMARY REG. DIST. NO. **3054** Registrar's No. **80**

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

1. PLACE OF DEATH a. COUNTY PIKE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN LOUISIANA		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
c. LENGTH OF STAY (In this place) 2 MO. 8 DA		d. STREET ADDRESS (If rural, give location) 5213 MINERVA	
d. FULL NAME OF HOSPITAL OR INSTITUTION MINERAL SPRING HOSPITAL		2069	

3. NAME OF DECEASED (Type or Print) DAVID ALLEN MANN	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) JULY 14, 1953
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH OCT. 24, 1949	9. AGE (In years last birthday) 3	10. MONTHS 8	11. DAYS 20	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) OWATONNA, MINN.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME RAYMOND C. MANN	13b. MOTHER'S MAIDEN NAME SELMA E. OLSON	14. NAME OF HUSBAND OR WIFE
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME RAYMOND C. MANN	ADDRESS 5213 MINERVA ST. LOUIS, MO.
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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 90 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma (nose, Throat & Ovarian cavity)		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 160x	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **MAY 6, 1953**, to **JULY 14, 1953**, that I last saw the deceased alive on **JULY 14, 1953**, and that death occurred at **5:10 pm.**, from the causes and on the date stated above.

23a. SIGNATURE D. C. Whitall	(Degree or title) 2	23b. ADDRESS Bowling Green, Mo.	23c. DATE SIGNED 7/14/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7/15/53	24c. NAME OF CEMETERY OR CREMATORY St. Louis, Mo.	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. July 15, 53	REGISTRAR'S SIGNATURE Berniece Collier	374	25. FUNERAL DIRECTOR'S SIGNATURE Sterne Funeral Home, Louisiana, Mo.	ADDRESS
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JUL 31 1953

AUG 17 1953

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.....
Student Embalmer

Signed *J.B. Stone*

Licensed Embalmer No. *4039*

P. O. Address *Louisiana, 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.