

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43744

State File No. \_\_\_\_\_

FILED JAN 4 1954

BIRTH NO. _____		REG. DIST. NO. <u>251</u>		PRIMARY REG. DIST. NO. <u>3048</u>		Registrar's No. <u>38</u>	
1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Nodaway</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chilford Wash.</u>		c. LENGTH OF STAY (in this place) <u>10 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chilford Washington</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>_____ Mo. 0740</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mr. William Bernard</u> b. (Middle) <u>McManus</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 26 1953</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 20 1891</u>		9. AGE (In years last birthday) <u>62</u>	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) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Near Clarksdale, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>John F. McManus</u>		13b. MOTHER'S MAIDEN NAME <u>Frances Rooney</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Mary McManus</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Mary McManus Chilford</u> ADDRESS _____			
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, assthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>ACUTE HEMORRHAGIC PANCREATITIS</u> 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. <u>ACTIVE DUODENAL ULCER</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>  <u>3 YRS.</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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>Dec. 15</u> , 19 <u>53</u> , to <u>Dec. 26</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Dec. 24</u> , 19 <u>53</u> , and that death occurred at <u>3:45 A. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>James J. Kadull</u> (Degree or title) <u>M. D.</u>			23b. ADDRESS <u>Conception Jet., Mo.</u>			23c. DATE SIGNED <u>12/26/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12/28/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Columba Cemetery</u>		24d. LOCATION (City, town, or county) (State), <u>Conception, Nodaway Mo</u>		
DATE REC'D BY LOCAL REG. <u>1-2-54</u>		REGISTRAR'S SIGNATURE <u>Bess Holt</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Stacy H. Phillips - Conception</u> ADDRESS _____			

(Licensed Embalmer's Statement on Reverse Side)

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

MAY 24 1955

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 Lester A. Phillips

Licensed Embalmer No. 1898

P. O. Address Stoughton, MA

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.