

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1193

1. PLACE OF DEATH

a. COUNTY Buchanan

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph

c. LENGTH OF STAY (in this place) 2 hrs.

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Missouri Meth. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE Missouri

b. COUNTY Buchanan

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural-Tremont

d. STREET ADDRESS (If rural, give location) R.R. #1, Agency

3. NAME OF DECEASED

a. (First) Keith b. (Middle) Wayne c. (Last) Mann

(Type or Print)

4. DATE OF DEATH (Month) (Day) (Year) 11/12/1954

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married

8. DATE OF BIRTH 7/15/1937

9. AGE (In years last birthday) 17 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 12 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student

10b. KIND OF BUSINESS OR INDUSTRY High School

11. BIRTHPLACE (State or foreign country) Lathrop, Mo.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Leasol Earl Mann

13b. MOTHER'S MAIDEN NAME Helen Grady

14. NAME OF HUSBAND OR WIFE None

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. None

17. INFORMANT'S SIGNATURE OR NAME Leasol Mann ADDRESS Agency, Missouri

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain Laceration

*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.

ANTECEDENT CAUSES

Due to (b) Auto accident

Due to (c) Compound fracture left femur, comminuted fracture left tibia

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH 4 hours 30

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

21a. ACCIDENT (Specify) Automotive

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway 169

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) GOWER CLINTON MO.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov. 11 54 9:45

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? Automobile accident

22. I hereby certify that I attended the deceased from Nov. 11, 1954 to Nov. 12, 1954, that I last saw the deceased alive on Nov 12, 1954, and that death occurred at 2:30 Am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John P. Mahony - M.D. 9

23b. ADDRESS Plattsburg, Mo.

23c. DATE SIGNED Nov. 13, 1954

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE 11/14/1954

24c. NAME OF CEMETERY OR CREMATORY #6 Cemetery

24d. LOCATION (City, town, or county) (State) Gower, Missouri

DATE REC'D BY LOCAL REG. Nov 15, 1954

REGISTRAR'S SIGNATURE Esther M. Allison 485-0

25. FUNERAL DIRECTOR'S SIGNATURE Rollins-Nash ADDRESS Edgerton, Mo.

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 *N. LeRoy Mooney*

Licensed Embalmer No. *4276*

P. O. Address *S. C. Mooney*

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.