

FILED DEC 27 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40217**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1322**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. LENGTH OF STAY (in this place) <b>47 years</b>	c. CITY OR TOWN <b>St. Joseph</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri Methodist Hospital</b>		STREET ADDRESS (If rural, give location) <b>2528 Faraon St.</b>	

3. NAME OF DECEASED (Type or Print) <b>Manota</b>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <b>December 17, 1954</b>
			<b>Vallery</b>	

5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>January 14, 1872</b>	9. AGE (In years last birthday) <b>82</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Plattsmouth, Nebraska</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Henry V. Eickleberry</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Charles A.</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Ruby Allison</b>	ADDRESS <b>104 S. 15th, St. Joseph, Mo.</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>arteriosclerotic heart disease</b>		<b>unknown</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arteriosclerosis general</b>		<b>unknown</b>
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 <b>4200</b>	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)
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 **March 24, 1954**, to **December 17, 1954** that I last saw the deceased alive on **Dec. 17, 1954**, and that death occurred at **1:00a. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Gustav P. Han</b>	23b. ADDRESS <b>M.D. Kirkpatrick Bldg. St. Joseph, Mo.</b>	23c. DATE SIGNED <b>12/21/1954</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>12/18/1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>Dec 21 1954</b>	REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>	485	25. FUNERAL DIRECTOR'S SIGNATURE <b>Heaton - Bowman</b>	ADDRESS <b>St. Joseph, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student, Embalmer

Signed *William Spalding*.....

Licensed Embalmer No. *453*

P. O. Address *395 104 St*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.