

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **11065**

FILED APR 18 1955

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 368	
1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (in this place) 60 years		c. CITY OR TOWN St. Joseph		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION D. O. A. General Hospital (Osteo)				f. STREET ADDRESS (If rural, give location) 1212 So. 6th St.			
3. NAME OF DECEASED (Type or Print) a. (First) Clarence b. (Middle) R. c. (Last) Mann			4. DATE OF DEATH (Month) (Day) (Year) April 3, 1955				
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH June 7, 1890	
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) manager		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (City and State or Foreign Country) Beatrice, Nebraska		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Ottis C. Mann		13b. MOTHER'S MAIDEN NAME Jenny Martin		14. NAME OF HUSBAND OR WIFE Mary E.			
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. 493-14-6147		17. INFORMANT'S SIGNATURE OR NAME Mrs. Mary Mann, 1212 S. 6th, St. Joseph, Mo. 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES DUE TO (b) Hypertension Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive and Arteriosclerotic Heart Disease					INTERVAL BETWEEN ONSET AND DEATH 5 minutes unknown unknown
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
I hereby certify that I attended the deceased from Oct. 9, 1953 , to Dec. 6, 1954 , that I last saw the deceased live on Dec. 6, 1954 , and that death occurred at 11:50a m. , from the causes and on the date stated above.							
22. SIGNATURE (Degree or title) Allen S. Herman M.D.				23b. ADDRESS 706 Francis, St. Joseph, Mo.		23c. DATE SIGNED 4/5/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 4/6/1955		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Mt. Zion Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri	
DATE REC'D BY LOCAL REG. April 12, 1955		REGISTRAR'S SIGNATURE Edwin M. Allison		485- FURNERAL DIRECTOR'S SIGNATURE Heaton-Bowman		ADDRESS St. Joseph, 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.....
Signature of Student Embalmer

Signed *James B. Hawkins*.....

Licensed Embalmer No. 453

P. O. Address 319 So. 10th 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.