

FILED JUL 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21193**

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 722

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Calif b. COUNTY San Diego <u>8040</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Joseph <u>4</u>)		c. LENGTH OF STAY (in this place) 1 year		c. CITY OR TOWN San Diego		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <u>8</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Wyatt Park Nursing Home 2705 Lafayette St.				e. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) Helen b. (Middle) B. c. (Last) Manaway			4. DATE OF DEATH (Month) (Day) (Year) July 14, 1955				
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed <u>2</u>	8. DATE OF BIRTH June 14, 1872		9. AGE (In years last birthday) 83	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) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and State or Foreign Country) Searsboro, Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Patrick Dalton		13b. MOTHER'S MAIDEN NAME Bridget Maher		14. NAME OF HUSBAND OR WIFE John W.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Mrs. Bess Opal, 2741 Seneca, St. Joseph, Mo.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis Gen. DUE TO (c) Myocardial Failure II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Terminal Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 15 Yrs 2 days 2 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4/42X				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) 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>1-27</u> , 19 <u>55</u> , to <u>7-13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7-13</u> , 19 <u>55</u> , and that death occurred at <u>5:25</u> a. m., from the causes and on the date stated above.							
23a. SIGNATURE H. W. Kieber, M.D. (Degree or title)				23b. ADDRESS St Joseph, Mo		23c. DATE SIGNED 7-15-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 7/16/1955	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.		
DATE REC'D BY LOCAL REG. July 19, 1955		REGISTRAR'S SIGNATURE Cathleen M. Allison <u>485-2</u>		25. FUNERAL DIRECTOR'S SIGNATURE Pheton-Bowman		ADDRESS St. Joseph, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

W. T. Nelson

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 *Leigene Wood*.....

Licensed Embalmer No. *3804*.....

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.