

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31205**
7776

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 2 weeks	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital		STREET ADDRESS (If rural, give location) 710 Doddridge Street	

3. NAME OF DECEASED (Type or Print)	a. (First) Ida	b. (Middle) F	c. (Last) Manning	4. DATE OF DEATH (Month) (Day) (Year) Sept 3, 1955
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5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH December 9, 1906	9. AGE (In years last birthday) 48	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis County, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Thomas Manning	13b. MOTHER'S MAIDEN NAME Caroline Hohmann	14. NAME OF HUSBAND OR WIFE Never Married
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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. Unknown	17. INFORMANT'S SIGNATURE OR NAME Miss Marion Manning	ADDRESS 710 Doddridge St.
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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 24 hrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Ovarian Tumor		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		2 yrs.	

19a. DATE OF OPERATION 8-27-55	19b. MAJOR FINDINGS OF OPERATION Tumor Left Ovary	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)
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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?
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22. I hereby certify that I attended the deceased from April, 1954, to 9-3-55, 19 , that I last saw the deceased alive on 9-2-55, 19 , and that death occurred at 1:00 A m., from the causes and on the date stated above.

23a. SIGNATURE Ho Schupil M.D. (Degree or title)	23b. ADDRESS 634 No. Grand, St. Louis Mo	23c. DATE SIGNED 9-5-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Sept 6, 1955	24c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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DATE REC'D BY LOCAL REG. SEP 6 1955	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Math Hermann & Son, Inc.	ADDRESS 2161 E. Fair Avenue
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m.j.B. (Licensed Embalmer's Statement on Reverse Side)

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

