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

THE DIVISION OF HEALTH OF MISSOURI

FILED APR 2 1956

STANDARD CERTIFICATE OF DEATH

State File No. 11113

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		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) _____		c. CITY OR TOWN St. Louis		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 Christian Hospital				e. STREET ADDRESS (If rural, give location) 4920 W. Florissant			
3. NAME OF DECEASED (Type or Print) Samuel		a. (First) _____		b. (Middle) _____		c. (Last) Manion	
4. DATE OF DEATH Mar. II 1956		(Month) _____ (Day) II (Year) 1956		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH April 14 1884		9. AGE (In years last birthday) 71		IF UNDER 1 YEAR: Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garment Worker		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Sullivan Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Daniel Manion		13b. MOTHER'S MAIDEN NAME Josephine Thurmond		14. NAME OF HUSBAND OR WIFE Clara Manion 4920 W. Florissant			
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. 498-05-7958		17. INFORMANT'S SIGNATURE OR NAME Clara Manion 4920 W. Florissant			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ulceria - Broncho pneumonia 7 days. ANTECEDENT CAUSES chronic nephritis Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS carcinoma of caecum Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION 3-1-56		19b. MAJOR FINDINGS OF OPERATION Neoplasm of caecum. 153x				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 2-6-56 , 19 56 , to 3-11- , 19 56 , that I last saw the deceased alive on 3-11- , 19 56 , and that death occurred at 12:25A m. , from the causes and on the date stated above.							
23a. SIGNATURE H. J. Stuebs M.D. (Degree or title) _____				23b. ADDRESS 608 Kingsland		23c. DATE SIGNED 3-12-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar 12 1956		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem		24d. LOCATION (City, town, or county) (State) St. Louis, Mo	
DATE REC'D BY LOCAL REG. MAR 12 1956		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Sullivan		ADDRESS 2849 N. Euclid	

(Licensed Embalmer's Statement on Reverse Side)

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 *Albert Mayfield*.....

Licensed Embalmer No. *30*.....

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.