

Health,  
Welfare  
Public  
Service

FILED AUG 1 - 1957

STANDARD CERTIFICATE OF DEATH

Registration District No. 144 Primary Registration District No. 1202 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hosp.</b>		Length of stay in 1b <b>6 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>332 No. Hardesty</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>FRANCES</b> Middle <b>ELAINE</b> Last <b>McMANUS</b>			4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>1957</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1915</b>	9. AGE (In years last birthday) <b>41</b>	F 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) <b>Clerk City Treas. Ofc. City Hall, K. C.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Mo. Rulo, Nebr.</b>	11. BIRTHPLACE (City and state or country) <b>U. S. A.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>James P. McManus</b>	13b. MOTHER'S MAIDEN NAME <b>Geneva E. McDermott</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>495-38-7110</b>	17. INFORMANT <b>James P. McManus, 332 No. Hardesty</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b> <b>with marked pulmonary</b> <b>Kyphoscoliosis Impairment</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <b>Congenital Spinal Deformity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>745X</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from <b>May 25 1957</b> to <b>July 13 1957</b> and last saw her/him alive on <b>July 13 1957</b> Death occurred at <b>3:15 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Paul A. G. Johnson M.D.</b> (Degree or title)	22b. ADDRESS <b>5111 Indep Ave. K.C. Mo</b>	22c. DATE SIGNED <b>7/15/57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-16-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Falls City, Nebr. Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Falls City, Nebraska</b>
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24. FUNERAL DIRECTOR <b>Melody-McGilley-Eylar Funeral Home</b>	ADDRESS <b>1800 E. Linwood, K. C, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>7-15-57</b>	26. REGISTRAR'S SIGNATURE <b>Neve Minshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Paul A. G. Johnson  
All diseases in Part I must be causally related.

W. P. H. Johnson  
5111 Indep  
Be 1-7943

12-5 PM

### 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 *J. W. Wair* .....

Licensed Embalmer No. *44550*

P. O. Address *Indep Me*

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.