

Health, Welfare, Public Service

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157

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

STANDARD CERTIFICATE OF DEATH

FILED AUG 22 1957

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. 395

1. PLACE OF DEATH a. COUNTY JASPER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JASPER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JOPLIN		c. CITY OR TOWN JOPLIN	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR MADDOX REST HOME - INSTITUTION 2302 PENN. AVE.		d. STREET ADDRESS (If outside, give location) 1515 SERGEANT AVE	
3. NAME OF DECEASED (Type or print) First (DR.) WILLIAM Middle GRANT Last MANESS		4. DATE OF DEATH Month AUGUST Day 11 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 1, 1865
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRACTICING PHYSICIAN		10b. KIND OF BUSINESS OR INDUSTRY MEDICAL	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME WILLIAM MANESS		13b. MOTHER'S MAIDEN NAME NANCY BULLARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNK		17. INFORMANT Address MRS. BERTHA PEARSON, 1515 SERGEANT AVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart disease DUE TO (b) Arterio Sclerosis Generalized DUE TO (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Attended by Dr. Shottle Collins 4200			INTERVAL BETWEEN ONSET AND DEATH less than 1 year
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.)	
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	
21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) W. Shottle Collins, M.D., County Health Officer		22b. ADDRESS County Dist. Nat'l Bldg.	
22c. DATE SIGNED 8-13-57			
23a. BURIAL, CREMATION, (Specify) BURIAL		23b. DATE 8-13-57	
23c. NAME OF CEMETERY OR CREMATORY MACIDONA CEMETERY, NEAR		23d. LOCATION (City, town, or county) (State) STELLA, MISSOURI	
24. FUNERAL DIRECTOR ADDRESS STEVE PARKER MORTUARY, JOPLIN, MO.		25. DATE RECD. BY LOCAL REG. 8-15-1957	
26. REGISTRAR'S SIGNATURE Dove Merriam			

County File Number 51-8-118
Date Filed AUG 20 1957

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 *F. M. Jones*

Licensed Embalmer No. *2319*

P. O. Address. *Joplin*

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.