

Health,  
& Welfare  
Public  
Service

FILED NOV 14 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36000  
STATE FILE NUMBER  
5030

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5030

300  
1-57

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>2700 Belleview</b>		Length of stay in lb <b>10 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>2700 Belleview.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LOYD</b> Middle <b>ALLEN</b> Last <b>MANNING</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>28,</b> Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 18, 1902</b>
9. AGE (In years last birthday) <b>55</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freight Checker</b>	11. BIRTHPLACE (City and state or country) <b>Sulphur, Oklahoma</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME: <b>Marion Jasper Manning</b>	
13b. MOTHER'S MAIDEN NAME <b>Malonia Katherine Fairchild</b>		14. NAME OF HUSBAND OR WIFE <b>Elizabeth Manning</b>	
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>44-26-4198</b>	17. INFORMANT Address <b>Mrs. Elizabeth Manning, 2700 Belleview, K.C. Mo</b>
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>Pulmonary Thrombosis</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>4200</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Generalized Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 yrs</b>
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.)		20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	
20d. INJURY OCCURRED WHILE AT <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 <u>1956</u> to <u>10/28/57</u> and last saw him alive on <u>10/27/57</u> Death occurred at <u>4:30 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Robert W Hamill</b> (Degree or title)		22b. ADDRESS <b>46205 C NICHOLS PKWY KCMO</b>	
22c. DATE SIGNED <b>10/28/57</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
23b. DATE <b>10/29/57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rush Springs Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Rush Springs, Oklahoma</b> (State)		24. FUNERAL DIRECTOR <b>QUIRK &amp; TOBIN-20 W. Linwood, K.C. Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>10-29-57</b>		26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
M. D.  
Robert W. Hamill



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 *E. C. Gibson*.....

Licensed Embalmer No. *4137*  
P. O. Address *K.C. Mo.*

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.