

FILED FEB 24 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005144
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 4319

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Camden</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield, Mo.</u>		c. CITY OR TOWN <u>Richland, Mo.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Hospital</u>		Length of stay in lb <u>3 days.</u>	
d. STREET ADDRESS (If outside, give location) <u>Rural Rt. # 1.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>H.</u> Last <u>MANES.</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>10,</u> Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 23, 1874</u>
9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer.</u>	11. BIRTHPLACE (City and state or country) <u>Cole Co, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Christphor C. Manes.</u>	
13b. MOTHER'S MAIDEN NAME <u>Delilah Story.</u>		14. NAME OF HUSBAND OR WIFE <u>Minnie Lee Manes.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. -----	
17. INFORMANT <u>Mrs. John Gibson</u>		Address <u>Richland, Mo Rural Rt</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 d.</u> <u>unknown</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>		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 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 <u>Springfield, Mo</u>		COUNTY <u>Greene</u> STATE <u>Mo</u>	
21. I attended the deceased from <u>2-8-58</u> to <u>death</u> and last saw him alive on <u>2-10-58</u> Death occurred at <u>7:00</u> p on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Harold B. Johnson</u> (Physician or Jailer)		22b. ADDRESS <u>Springfield, Mo</u>	
22c. DATE SIGNED <u>2-13-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>Feb 13/58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CampGround Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Stoutland, Mo</u>		(State) <u>Rural Rt.</u>	
24. FUNERAL HOME OR ADDRESS <u>Hedges Funeral Home Richland, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>2-17-58</u>	
26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 4 1058

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 *Clarence Moore*

Licensed Embalmer No. *4896*

P. O. Address *Waynesville, N.C.*

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.