

Health,
Welfare
Public
Service

SPRINGFIELD, MISSOURI

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009570
STATE FILE NUMBER

FILED MAR 17 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 254

1. PLACE OF DEATH a. COUNTY GREENE			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY GREENE		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1012 E. Walnut		Length of stay in lb 22 Yrs	d. STREET ADDRESS (If outside, give location) 1012 E. Walnut		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALIENE Middle MANNING Last MANNING			4. DATE OF DEATH Month March Day 10 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 March 1895	9. AGE (In years last birthday) 62	FUNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Tom Coffin		13b. MOTHER'S MAIDEN NAME Betty Davers		14. NAME OF HUSBAND OR WIFE Tom Manning	
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. No	17. INFORMANT Address Tom Manning Springfield, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis, acute					INTERVAL BETWEEN ONSET AND DEATH Min. or 2
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
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.)		
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 COUNTY STATE	
21. I attended the deceased from 1949 to 3-10-58 and last saw her alive on 3-9-58 Death occurred at 1:00 P. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE GB Lemmon, MD (Degree or title)		22b. ADDRESS 609 Cherry Springfield, Missouri		22c. DATE SIGNED 3-12-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-13-58	23c. NAME OF CEMETERY OR CREMATORY HUMANSVILLE CEM.		23d. LOCATION (City, town, or county) (State) HUMANSVILLE, MO.
24. FUNERAL DIRECTOR J. Klingner ADDRESS SPRINGFIELD MO.		25. DATE RECD. BY LOCAL REG. 3-14-58	26. REGISTRAR'S SIGNATURE Effie G. Melton		

(Licensed Embalmer's Statement on Reverse Side)

1hg

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 *Glen D Williams*

Licensed Embalmer No. *4651*

P. O. Address *Springfield*

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.