

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014834

STATE FILE NUMBER

FILED MAY 6 1958

Registration District No. 171 Primary Registration District No. 4267 Registrar's No. 18

300
1-57
549

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Odessa		c. CITY OR TOWN Odessa	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Length of stay in 1b 30 Yrs.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Joseph R. Manking			4. DATE OF DEATH Month Day Year April 25, 1958		
5. SEX Male	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 Jan. 6, 1896	9. AGE (In years last birthday) 62	10. FUNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Standard Oil Co. dealer	10b. KIND OF BUSINESS OR INDUSTRY Gasoline	11. BIRTHPLACE (City and state or country) Ray Co., Mo.	12. CITIZEN OF WHAT COUNTRY? 0
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13a. FATHER'S NAME John F. Manking	13b. MOTHER'S MAIDEN NAME Mollie Showalter	14. NAME OF HUSBAND OR WIFE Minnie Manking
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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) Yes WW1	16. SOCIAL SECURITY NO. 487-10-0468	17. INFORMANT Address Mrs. Minnie Manking, Odessa, Mo.
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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) Acute Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 1/4 Hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) _____ DUE TO (c) _____		4201
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 <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 **April 25, 1958 1:00 PM** to **April 25 '58 4:45 PM** and last saw him alive on **April 25, 1958**
Death occurred at **4:45 PM** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Seal L. Watson M.D.	22b. ADDRESS Odessa, Mo.	22c. DATE SIGNED 4-28-58
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	April 27, 1958	Odessa Cemetery	Odessa, Mo.

24. FUNERAL DIRECTOR Husman-Sparks ADDRESS Odessa, Mo.	25. DATE RECD. BY LOCAL REG. April 29, 1958	26. REGISTRAR'S SIGNATURE Emma Davidson
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, registrar, etc. may stamp name and address on this certificate for identification purposes. All diseases in Part I must be causally related.

