

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-016149  
STATE FILE NUMBER

FILED MAY 14 1958

Registration District No. ....

318

Primary Registration District No. ....

1003

Registrar's No. ....

4913

300

-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>		Length of stay in lb <b>23</b>	d. STREET ADDRESS (If outside, give location) <b>1720 So. 9th., St</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>OSCAR</b> First <b>L.</b> Middle <b>MANNING</b> Last			4. DATE OF DEATH <b>MAY 7, 1958</b> Month Day Year		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/24/192</b>	9. AGE (In years Last birthday) <b>65</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	11. BIRTHPLACE (City and state or country) <b>Ozark County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>George Scott Manning</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Bell Manning</b>
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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) <b>Yes W.W.#1</b>	16. SOCIAL SECURITY NO. <b>486 12 4649</b>	17. INFORMANT Address <b>Ernest Manning-1720 So. 9th., St.</b>
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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) <b>Delirium Tremens</b> DUE TO (b) <b>Chronic alcoholism</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b>
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.) <b>307x</b>
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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
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21. I attended the deceased from <b>5/5/58</b> to <b>5/7/58</b> and last saw her alive on <b>5/7/58</b> Death occurred at <b>7: A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Deceased or title) <b>Wilson J. Cooper M.D.</b>	22b. ADDRESS <b>1515 LAFAYETTE AVE</b>	22c. DATE SIGNED <b>5/7/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5/12/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Jefferson Brks. Mo.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Noydell Funeral Home-1926 Allen Ave</b>	25. DATE RECD. BY LOCAL REG. <b>MAY 8 '58</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b> L.P.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

