

t. Health,  
, & Welfare  
S. Public  
th Service

THE STANDARD CERTIFICATE OF DEATH

58-028830

STATE FILE NUMBER

FILED SEP 8 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 854

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Springfield 0390</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Handley Hospital</b>		Length of stay in 1b <b>47 years</b>	d. STREET ADDRESS (If outside, give location) <b>Route 11, Box 486</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES HENRY MANESS</b>			4. DATE OF DEATH Month Day Year <b>August 31, 1958</b>		
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>May 20, 1874</b>		9. AGE (In years last birthday) <b>84</b> 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) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Frisco Railway</b>	11. BIRTHPLACE (City and state or country) <b>Florence, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>G W Maness</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Cramer</b>		14. NAME OF HUSBAND OR WIFE <b>-----</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>None</b>	17. INFORMANT Address <b>Mrs Hettie L. Campbell, Kansas City, 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>Cardio-renal Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Aug-12, 1958 to Aug-31, 1958</b>
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) <b>442X</b>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2		

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 **8/12/58** to **8/31/58** and last saw <sup>her</sup> ~~him~~ alive on **8/31/58**  
Death occurred at **12:50 p.m.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Lyman D. Brown M.D.</b>	22b. ADDRESS <b>31 1/2 College, Springfield, Mo</b>	22c. DATE SIGNED <b>9/1/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Sept 2, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Jewell E. Windle R.W. Springfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>9-2-1958</b>	26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

SEP 30 1958

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 *Bernard F. Wright*

Licensed Embalmer No. *4293*

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.