

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003813
STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 317 Primary Registration District No. 544 Registrar's No. 72

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1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>4607 Webster Groves</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hosp.</u>		Length of stay in lb <u>7 Hours</u>	d. STREET ADDRESS (If outside, give location) <u>1401 Azalea Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES E. MANAHAN</u>			4. DATE OF DEATH Month Day Year <u>Jan. 6 1959</u>		
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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. 15, 1903</u>	9. AGE (In years last birthday) <u>55</u>	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) <u>District Sales Mgr.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Hussmann Ligonier Co.</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Edmund Manahan</u>	13b. MOTHER'S MAIDEN NAME <u>Cecelia Kaut</u>	14. NAME OF HUSBAND OR WIFE <u>Grace C. Manahan</u>
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15. WAS DECEASED EVER IN U. S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD? (Yes, name of branch) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>492-01-5097</u>	17. INFORMANT <u>Grace C. Manahan</u> Address <u>1401 Azalea Dr.</u>
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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) <u>Chr. Nephritis with Uremia</u> DUE TO (b) <u>Hypertensive CV Disease</u> DUE TO (c) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr (2)</u> <u>6/16/47</u> <u>6 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bronchopneumonia, bilateral 443x</u>		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.) <u>443x</u>
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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 <u>St. Louis</u>	COUNTY <u>St. Louis</u>	STATE
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21. I attended the deceased from 1/28/44 to 1/6/59 and last saw him alive on 1/6/59 3:00 PM
Death occurred at 3:00 P. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>A. Makada, MD</u>	22b. ADDRESS <u>Medical West Bldg, Clayton</u>	22c. DATE SIGNED <u>1/7/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Jan. 9, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
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24. FUNERAL DIRECTOR <u>Kriegshauser 4228 S. Kingshighway</u>	25. DATE RECD. BY LOCAL REG. <u>1-7-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy, MD</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *William A. White*

Licensed Embalmer No. *4281*

P. O. Address *228 1/2 ...*

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.