Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

FILED FEB 16 1959

STANDARD CERTIFICATE OF DEATH

59-004599
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 155

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY DeKalb	
b. CITY OR TOWN St. Joseph	Inside Limits Yes ☒ No ☐	c. CITY OR TOWN Clarksdale c 3.20 c	Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION State Hosp. # 2	Length of stay in 1b 8 Months	d. STREET ADDRESS RFD (If outside, give location)	Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First: RAYMOND	Middle:	Last: MC MANUS	4. DATE OF DEATH Month, Day, Year: February 6, 1959			
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Sept. 28, 1910	9. AGE (In years last birthday): 48	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): None	10b. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (City and state or country): Clarksdale, Mo.	12. CITIZEN OF WHAT COUNTRY?: USA			
13a. FATHER'S NAME: Thomas McManus	13b. MOTHER'S MAIDEN NAME: Clara Kessler	14. NAME OF HUSBAND OR WIFE: None				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Clarence McManus	Address: Clarksdale, Mo.			

MEDICAL CERTIFICATION

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 Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 Days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Chronic Epilepsy — Unknown

DUE TO (c) Mal Nutrition, General Debility — 10 Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): A Patient in State Hospital # 2 Since May 14, 1959 Diagnosis 3533

19. WAS AUTOPSY PERFORMED? 1 YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.): Mental Deficiency, Zdiopathic Moderate		
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	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 Jan. 30, 1959 to Feb. 5, 1959 and last saw him alive on Feb. 6, 1959
Death occurred at 2:05 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): H. F. Mundy M.D.	22b. ADDRESS: St Joseph, Mo.	22c. DATE SIGNED: Feb 6 1959	
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Feb. 9, 59	23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery	23d. LOCATION (City, town, or county) (State): Hurlingen, Mo.
24. FUNERAL DIRECTOR: H.O. Sidenfaden & Son KPY.	ADDRESS: St Joseph, Mo.	25. DATE RECD. BY LOCAL REG.: Feb 6 1959	26. REGISTRAR'S SIGNATURE: Mrs Clark Woodell

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All disease in Part I must be causally related.

Dr. H. F. Mundy

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 Robert L Gaple

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

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.