

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009934

STATE FILE NUMBER

FILED APR 7 1959 Registration District No. 163 Primary Registration District No. 3031 Registrar's No. 28

300
1-57

1. PLACE OF DEATH a. COUNTY Jefferson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jefferson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN DeSoto		c. CITY OR TOWN DeSoto <u>0503</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 503 Rollins St.		d. STREET ADDRESS 503 Rollins St.	
Length of stay in 1b 6 Yrs.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Harry N.M.N. Maness			4. DATE OF DEATH Month Day Year Mar. 30, 1959		
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5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1889	9. AGE (In years last birthday) 69	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) Stat. Fireman	10b. KIND OF BUSINESS OR INDUSTRY Ice Plant	11. BIRTHPLACE (City and state or country) DeSoto, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Effie Lee Maness (Dec)
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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) No	16. SOCIAL SECURITY NO. 497-07-6335	17. INFORMANT Kenneth Maness	Address 516 Couch Kirkwood, 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) Coronary thrombosis with myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 15-minute
DUE TO (b) arteriosclerosis of coronary arteries?		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201		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.)
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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 Death occurred at March 30, 1959, 2:00 p.m.	and last saw him alive on March 30, 1959
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22a. SIGNATURE (Degree or title) Thomas A. Donnell MD	22b. ADDRESS DeSoto Mo	22c. DATE SIGNED 3-30-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/2/59	23c. NAME OF CEMETERY OR CREMATORY Woodlawn	23d. LOCATION (City, town, or county) (State) DeSoto Mo.
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24. FUNERAL DIRECTOR J. Lee Mothershead	ADDRESS DeSoto, Mo.	25. DATE RECD. BY LOCAL REG. Apr. 2-1959	26. REGISTRAR'S SIGNATURE Marie Patricia
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

APR 21 1959

RECEIVED
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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 *J. F. [Signature]*

Licensed Embalmer No.

P. O. Address *[Handwritten Address]*

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.