

FEDERAL BUREAU OF INVESTIGATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035281

FILED VS OCT 19 1959

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1038

UNRECORDED

| | | | | | | | |
|--|--|--|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph, Missouri</u> Length of stay in 1b <u>70 years</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2613 Olive Street (Home)</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u> c. CITY OR TOWN <u>St. Joseph, Missouri</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2613 Olive Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>MANNAN</u> Last <u>MANNAN</u> | | | 4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>13</u> Year <u>1959</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 13, 1872</u> | 9. AGE (last birthday) <u>87</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | | 11. BIRTHPLACE (City and state or country) <u>Olney, Illinois</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13a. FATHER'S NAME <u>Winfield Scott Hill</u> | | 13b. MOTHER'S MAIDEN NAME <u>Alta Adeline Cheek</u> | | | |
| 14. NAME OF HUSBAND OR WIFE <u>Dova C. Mannan</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>489-36-1905</u> | | | |
| 17. INFORMANT <u>Mr. Galen S. Mannan, St. Joseph, Mo.</u> | | 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>Gastric Hemorrhage -</u> (b) <u>Acute G.I. Upset - Severe vomiting 48hr</u> (c) <u>Arteriosclerosis Gen.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Acute.</u> <u>Yrs.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Old Cerebral Vascular Accidents</u> | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 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.) | | | | | |
| 20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u> | | 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 | | |
| 21. I attended the deceased from <u>4-29-50</u> , to <u>10-13-59</u> and last saw her <u>him</u> alive on <u>10-13-59</u> Death occurred at <u>9:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <u>Robert W. Kieber M.D.</u> (Degree or title) | | | 22b. ADDRESS <u>St. Joseph, Mo.</u> | | 22c. DATE SIGNED <u>10-14-59</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Oct 15, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>St. Joseph, Missouri</u> (State) | | | |
| 24. FUNERAL DIRECTOR <u>Hector Bauman</u> ADDRESS <u>St. Joseph, Missouri</u> | | 25. DATE RECD. BY LOCAL REG. <u>Oct. 16, 1959</u> | | 26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u> | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 23 1959

APR 2 1960

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 Ernest Wood

Licensed Embalmer No. 3804

P. O. Address 345 10th St

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.