

**MURKIN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS FEB 1 1960**

**212202**

STATE FILE NUMBER  
**59-047008**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>24 hrs.</b>	c. CITY OR TOWN <b>Rock Hill</b>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>9811 Cottonwood Lane</b>

3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>CHARLES</b> Last <b>MANEWAL</b>	4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>1959</b>
--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1883</b>	9. AGE (last birthday) <b>76 yrs.</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR. Hours _____ Min. _____
-----------------------	----------------------------------	---	---	--	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Superintendent</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
--	--	--	---

13a. FATHER'S NAME <b>John Manewal</b>	13b. MOTHER'S MAIDEN NAME <b>Kate Hackman</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs. Josephine E. Manewal</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.	17. INFORMANT Address <b>Mrs. Josephine Manewal, 9811 Cottonwood La</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>ANEURYSM, ABDOM. AORTA</b>	INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ARTERIOSCLEROSIS</b>	
DUE TO (c) <b>451X</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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 _____ a.m. _____ p.m. Month, Day, Year _____
---

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 **Sept 1959** to **Dec 1959** and last saw her/him alive on **Dec 31, 1959**  
Death occurred at **11:40 P.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Doctor or title) <b>Burton C. Sholtz M.D.</b>	22b. ADDRESS <b>4652 MARYLAND</b>	22c. DATE SIGNED <b>1/2/60</b>
--	--------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Jan. 4, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
---	----------------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <b>Beiderwieden F.H.Inc., 1936 St. Louis</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 4 1960</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>
--	---	---

*Mr. J. B.*

DOCUMENT

MEDICAL CERTIFICATION

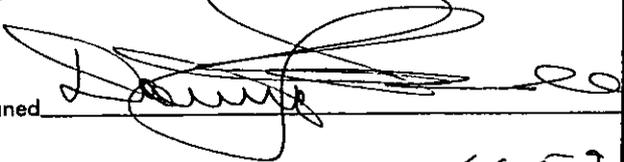
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 452  
P. O. Address St Louis

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.