

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003772

FILED VS. FEB 1 0 1960

2 818

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Barnes Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4907 W. Pine Ave	
3. NAME OF DECEASED (Type or print) JAMES		First VICTOR		Last MANNING	
4. DATE OF DEATH January 22 1960		Month January		Day 22 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/27/1878	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (City and state or country) Fentress, Texas	
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME James B. Manning		13b. MOTHER'S MAIDEN NAME Victoria Miller	
14. NAME OF HUSBAND OR WIFE late, Mary Manning		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. yes	
17. INFORMANT Mrs. Paul O. Willms		Address Montes Ave 530			
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 420.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic bronchitis					INTERVAL BETWEEN ONSET AND DEATH 1 day years
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.		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 Jan. 14, 1953 to Jan. 22, 1960 and last saw ^{her} him alive on Jan. 22, 1960 Death occurred at 9:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Jos. M. Chrenstein, M.D.		(Degree or title)		22b. ADDRESS 4500 Olive St	
22c. DATE SIGNED 1/23/60		23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 1/25/60	
23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		23d. LOCATION (City, town, or county) St. Louis County Mo.		(State)	
24. FUNERAL DIRECTOR C.R. Lupton and sons		ADDRESS 7233 Delmar Blvd		25. DATE RECD. BY LOCAL REG. JAN 25 1960	
26. REGISTRAR'S SIGNATURE Paul Smith, M.D.					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I 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 Arnold W. Schoe

Licensed Embalmer No. 3864

P. O. Address St. Louis, 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.