

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-004907

FILED VS FEB 1 1960

Registration District No. # 373 Primary Registration District No. 4545 Registrar's No. 6 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY WEBSTER				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MARSHFIELD MO 25VRS		Length of stay in 1b		c. CITY OR TOWN MARSHFIELD MO		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 504 E. WASHINGTON				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 504 E. WASHINGTON		
3. NAME OF DECEASED (Type or print) First ERASTIC Middle E. Last MANNING				4. DATE OF DEATH Month JAN Day 19 Year 1960				
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-10-1887		
9. AGE (last birthday) 72		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) RET BUTCHER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) MISSOURI		12. CITIZEN OF WHAT COUNTRY U.S.A	
13a. FATHER'S NAME HENRY MANNING			13b. MOTHER'S MAIDEN NAME RUTH RODDEN			14. NAME OF HUSBAND OR WIFE ABBIE		
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. 492-03-5356		17. INFORMANT ABBIE MANNING, MARSHFIELD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Hepatic Coma							2 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Complete obstruction, Pile & Bowel							17 days	
DUE TO (c) Carcinoma of Ampulla of Vater with metastatic spread							11 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Urinary obstruction - uremia,						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.) Last operation a cholecystoduodenostomy on 6/17/59 at Baptist Hosp. Spfld. Mo.				
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 June 27, 1953 to Jan. 17, 1960 and last saw ^{them} him alive on Jan 18, 1960 P.M. Death occurred at 4:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) J. M. Macdonnell M.D.				22b. ADDRESS Marshfield Mo.		22c. DATE SIGNED 1-28-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-30-1960		23c. NAME OF CEMETERY OR CREMATORY MISSION HOME		23d. LOCATION (City, town, or county) (State) WEBSTER CO MO		
24. FUNERAL DIRECTOR BARBER-EDWARDS-MARSHFIELD				25. DATE RECD. BY LOCAL REG. 1-29-60		26. REGISTRAR'S SIGNATURE <i>J. Francis</i>		

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 *[Handwritten Signature]*

Licensed Embalmer No. 38
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.