

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 31 1960

=60-021759

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1663

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u>		Length of stay in 1b	c. CITY OR TOWN <u>Webster Groves</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1300 Grant Rd.</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Pettigrew</u> Last <u>Manning</u>			4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1960</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-9-1874</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Anna, Illinois</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Samuel Pettigrew</u>		13b. MOTHER'S MAIDEN NAME <u>Kate Flarrety</u>		14. NAME OF HUSBAND OR WIFE <u>Lewis L. Manning</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>none</u>	17. INFORMANT <u>Mr. Lewis L. Manning</u> Address <u>1300 Grant Rd. Mo.</u>		

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 <u>1 week</u> <u>1 month</u>
IMMEDIATE CAUSE (a) <u>Bronchial - Pneumonia, bilateral</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congestive Heart Failure.</u>		
DUE TO (c) <u>Generalized arteriosclerosis</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, but not related to the terminal disease condition given in PART I (a) <u>Fracture of Hip</u> <u>Parotitis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 May 2, 1960 to May 23, 1960 and last saw her him alive on May 23, 1960  
Death occurred at 10:55 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph W. West M.D.</u>		22b. ADDRESS <u>109 N. Taylor Kirkwood Mo.</u>		22c. DATE SIGNED <u>5/24/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>May 25, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Missouri.</u>	
24. FUNERAL DIRECTOR <u>C.R. Lupton and Sons 7233 Demar Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>5-25-60</u>	REGISTRAR'S SIGNATURE <u>John B. Manly M.D.</u>	

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, working under my personal supervision.

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

Signed Clarence H. Moore

Licensed Embalmer No. 401  
P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.