MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1140 61-006711 STATE FILE NUMBER

FILED VS FEB 20 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Mo. Baptist Hospital — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1508 Mr. Montgomery — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle T. Last MANNING
4. DATE OF DEATH: Month FEB. Day 2 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10/25/1889
9. AGE (last birthday): 71 — 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): machinist
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (City and state or country): Perryville Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Mark Manning
13b. MOTHER'S MAIDEN NAME: (unknown)
14. NAME OF HUSBAND OR WIFE: Lavieda Manning
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ********
16. SOCIAL SECURITY NO.:
17. INFORMANT: Joseph Manning — Address: 2340 Montgomery

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PULMONARY EMBOLISM
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): THROMBOSIS OF PROSTATIC PLEXUS
DUE TO (c): 464X
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): MYOCARDIAL HYPERTROPHY & CORONARY SCLEROSIS
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1-7-61, to 2-2-61 and last saw him alive on 11:00 A.M. 2/2/61
Death occurred at 11:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): William R. Pleth M.D.
22b. ADDRESS: St. Mary's Baptist Hospital
22c. DATE SIGNED: 2/3/61
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/6/1961
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Mo.
24. FUNERAL DIRECTOR: JOHN STYGAR & SON — ADDRESS: 5541 RIVERVIEW BLVD
25. DATE RECD. BY LOCAL REG.: FEB 5 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — DOCUMENT — 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 me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed J H Rister

Licensed Embalmer No. 3980

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.