

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

-61-030941

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7608

STATE FILE NUMBER

FILED AUG 23 1961

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 <u>ST. LOUIS</u>			Length of stay in 1b		c. CITY OR TOWN <u>IMPERIAL</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LUKE'S HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>R.R 1 Box 388 C</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM C MANES</u>			4. DATE OF DEATH Month Day Year <u>AUG 14 1961</u>		
5. SEX <u>MALE</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>DEC 5 1903</u>	9. AGE (last birthday) <u>57</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER POST-DISPATCH</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MISSOURI</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>WILLIAM C MANES</u>		13b. MOTHER'S MAIDEN NAME <u>EUGENIA MC CUNE</u>		14. NAME OF HUSBAND OR WIFE <u>MILDRED MANES</u>	
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 Address <u>MILDRED MANES R1 Box 388 C IMPERIAL MO.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma from jaw to brain</u> DUE TO (b) <u>Carcinoma, mucinous adenocarcinoma of mandible</u> DUE TO (c) <u>1961</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
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 <u>4-22-61</u> to <u>8-13-61</u> and last saw her/him alive on <u>8-13-61</u> Death occurred at <u>8-11-61</u> <u>1 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Meredith Forstall Payne M.D.</u>			22b. ADDRESS <u>3720 Washington</u>		22c. DATE SIGNED <u>8-16-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>AUG 17 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETER & PAUL CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>	
24. GENERAL DIRECTOR ADDRESS <u>Thomas Hunt 2906 Gravoie</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 16 1961</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith M.D.</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

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 *Calvin Thompson*
Licensed Embalmer No. 4861

P. O. Address Clayton 5, 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.