V. S. No. 2. A

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

a

Registration District No. 387 File No. 34144

Primary Registration District No. 5540 Registered No.

1 PLACE OF DEATH

County: Howell

Township: Dry Creek

Village: Pomona

City: (NO. , St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME: James Henry Glanville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

TE OF BIRTH: August (Month) 15th (Day) 1846 (Year)

E: 76 yrs. 4 mos. 4 ds.

If LESS than 1 day, hrs. or min.?

CUPATION
Trade, profession, or ticular kind of work: Retired. Formerly

General nature of industry ness, or establishment in ch employed (or employer): engaged in mining and farming

THPLACE (City or town, or foreign country): Near Linden Wisconsin

10 NAME OF FATHER: Johnson Glanville

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Cornwall England

12 MAIDEN NAME OF MOTHER: Mary Ann Pedler

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): England.

E ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

formant): Birdie Glanville

(Address): Pomona Mo

ed May 21 1923. W. Carrell Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH: December (Month) 19th (Day) 1922 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 5, 1922, to Dec 19, 1922 that I last saw h. alive on Dec 19, 1922 and that death occurred, on the date stated above, at about 1:00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic gastro-enteritis (Chronic Intestinal Catarrh)

1 mo (Duration) Several yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) age

(Duration) yrs. mos. ds.

(Signed) D D Coy M. D.

Dec 20, 1922 (Address) Pomona Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 7 yrs. 2 mos. 7 ds. In the State 7 yrs. 2 mos. 7 ds.

Where was disease contracted if not at place of death?

~~Former or~~ usual residence Pomona Mo

19 PLACE OF BURIAL OR ~~REMOVAL~~: Pomona Mo

DATE OF BURIAL: Dec 20, 1922

20 UNDERTAKER: McFarland

ADDRESS: West Plains Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

V. S. No. 2. A

**MISSOURI STATE BOARD OF HEAL**
**BUREAU OF VITAL STATISTICS**
**CERTIFICATE OF DEATH**

**1 PLACE OF DEATH**

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ..... St.; ..... Ward)

[If death occurre hospital or insti give its NAME of street and nu

**2 FULL NAME** .....

**PERSONAL AND STATISTICAL PARTICULARS**

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

6 DATE OF BIRTH
..... (Month) ..... (Day), 1..... (Year)

7 AGE
.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed....., 191....., .....
Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH
..... (Month) ..... (Day), 191..

17 I HEREBY CERTIFY, that I attended deceased
....., 191....., to....., 191
that I last saw h.....alive on....., 191
and that death occurred, on the date stated above, at.....
The CAUSE OF DEATH* was as follows:

..... (Duration).....yrs.....mos.....

CONTRIBUTORY .....
(Secondary)
..... (Duration).....yrs.....mos.....

(Signed).....

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Caus (1) Means of Injury; and (2) whether Accidental, Suicidal or Hom

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos....

Where was disease contracted if not at place of death?.....

Former or usual residence.....

| 19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL |
|---|---|
| | ....., 1 |
| 20 UNDERTAKER | ADDRESS |