

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FEB MAR 12 1940
STANDARD CERTIFICATE OF DEATH

State File No. 5105
Registrar's No. 1935

Registration District No. 791 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: St. Lukes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 7 Days
years, months or days

3. (a) PRINT FULL NAME Grace Irene Glove

3. (b) If veteran, name war ***** 3. (c) Social Security No. *****

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Charles A. Glove 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased February 27 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 11 29 hr. min.

9. Birthplace Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife
New York

11. Industry or business New York

12. Name H.N. Brewster

13. Birthplace New York
(City, town, or county) (State or foreign country)

14. Maiden name VanPatton
(City, town, or county) (State or foreign country)

15. Birthplace New York
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Charles Glove
(b) Address Centralia Illinois

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 27 1940
(Month) (Day) (Year)

(c) Place: burial or cremation Centralia Illinois

18. (a) Signature of funeral director Peetz Brothers
(b) Address 3029 Lafayette Ave
19. (a) FEB 26 1940 (b) J. F. Gudech
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County _____
(c) City or town Centralia NR
(If outside city or town limits, write "RURAL")
(d) Street No. 910 E. Third St
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 25
year 1940 hour 9:50 minute a. M.

21. I hereby certify that I attended the deceased from 1930, 19, to Feb 25, 1940;
that I last saw him alive on Feb 25, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis, acute, toxic Duration 4 days

Due to Cholelithiasis (for Choleliths & cholelithiasis) Duration 4 yrs.

Due to 126
Other conditions (Include pregnancy within 3 months of death)

Major findings: Choleliths & cholelithiasis PHYSICIAN _____
Of operations

Of autopsy Myocarditis, acute
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Leah (M. D. or other) _____
Address 461 N. Tyler Date signed 2-25-40

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.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
Paul D. Owen

Licensed Embalmer No.....
9245

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 this body is not embalmed, above space should be left blank.