DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18665

FILED JUN 17 1940

Registration District No. 410 Primary Registration District No. 5-553/13 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: Jackson County
(a) County
(b) ~~City or town~~ Near Lee's Summit
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: On train near Lee's Summit, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 (Specify whether years, months or days)
In this community Non-Resident

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 926 Felix
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Gaylord G. Glidewell 434
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Male
5. Color or race Wh
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs. Nellie Mae Glidewell
6. (c) Age of husband or wife if alive 28 years
7. Birth date of deceased July (Month) 4 (Day) 1910 (Year)

8. AGE: Years 29 Months 10 Days 5 If less than one day hr. min.

9. Birthplace Milan (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Baker
11. Industry or business
FATHER 12. Name Robert Glidewell
13. Birthplace Milan (City, town, or county) Missouri (State or foreign country)
MOTHER 14. Maiden name Mary Whitaker
15. Birthplace Milan (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Mrs. Nellie Mae Glidewell
(b) Address St. Joseph, Missouri
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof May 10-40 (Month) (Day) (Year)
(c) Place: burial or cremation St. Joseph, Mo.
18. (a) Signature of funeral director J. W. Wagner
(b) Address Kansas City, Mo.
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9th year 1940 hour 6:00 minute P M.
21. I hereby certify that I attended the deceased from ..., 19..; to ..., 19..; that I last saw him alive on ..., 19..; and that death occurred on the date and hour stated above.
Deputy Coroner

	Duration
Immediate cause of death: Bronchial fibro-caseous	
Due to: pulmonary tuberculosis &	
Due to: cavitation & superimposed	
Other conditions (Include pregnancy within 3 months of death): miliary tuberculosis	

Major findings:
Of operations
Of autopsy

PHYSICIAN
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? (Specify type of place)
While at work (Specify what)
(e) Cause of injury

23. Signature Preston Burlew (M. D. or other)
Address K. C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Cecil R. Matthes

Licensed Embalmer No. 3807

P. O. Address K.C., 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.

E. No. 2B
—2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

ENA MOORE

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18665

Registration District No. 400 Primary Registration District No. 5-5-53 B Registrar's No. 129 a

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Prairie (If outside city or town limits write "RURAL" and name of township)

(c) Name of hospital or institution: on Tram near Lee's Summit (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (specify whether years, months or days)

In this community non resident

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan

(c) City or town St Joseph (If outside city or town limits write "RURAL")

(d) Street No. 926 Felix (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Gaylord G. Glidewell

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex m

5. Color or race wh

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife Nellie May Glidewell

(c) Age of husband, or wife, if alive ..... years

7. Birth date of deceased July - 4 - 1910 (Month) (Day) (Year)

8. AGE: Years 29 Months 10 Days 5 If less than one day ..... hr. ..... min.

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

10. Usual occupation Baker

11. Industry or business

FATHER
12. Name Robert Glidewell
13. Birthplace Milan (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Mary Whitaker
15. Birthplace Milan (City, town, or county) Mo (State or foreign country)

16. (a) Informant Mrs Nellie May Glidewell

(b) Address St Joseph Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof May-10-1940 (Month) (Day) (Year)

(c) Place: burial or cremation St Joseph Mo

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City Mo

19. (a) 7-11-40 (Date received local registrar) (b) Sarah G. Barnes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9 year 1940 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw h... alive on ..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral fibro caseous

Due to Pulmonary Tuberculosis Cavitation & Super-imposed Miliary Tuberculosis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Victor B. Bullers (M.D. or other)

Address K. C. Mo Date signed

SUPPLEMENTARY