No. 2
11-10-39
-17-39
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FILED OCT 10 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32057

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 775

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

1. PLACE OF DEATH:

(a) County: GREENE

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

(c) Name of hospital or institution: 1900 MEREDITH AVE.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 2 (Specify whether years, months or days)

In this community:

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO. (b) County: GREENE.

(c) City or town: SPRINGFIELD
(If outside city or town limits write "RURAL")

(d) Street No.: 1900 MEREDITH
(If rural, give location)

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

3. (a) PRINT FULL NAME: WILLIAM THOMAS GLENN

3. (b) If veteran, name war: No

3. (c) Social Security No.: None.

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widower

6. (b) Name of husband or wife: Unknown

6. (c) Age of husband or wife if alive: Dec years

7. Birth date of deceased: Sep (Month) 17 (Day) 1852 (Year)

8. AGE: Years 88 Months 0 Days 7 If less than one day ____ hr. ____ min.

9. Birthplace: Unknown (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation: Retired Drayman 0

11. Industry or business: Draying 9

MOTHER FATHER

12. Name: Anderson Glenn 9

13. Birthplace: Unknown (City, town, or county) Mo. (State or foreign country)

14. Maiden name: Kate Triplett

15. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant: Ada Williams

(b) Address: Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sep 26 1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Greenlawn

18. (a) Signature of funeral director: J. W. Kingsley & Co

(b) Address: Springfield, Mo.

19. (a) 9-26-40 (Date received local registrar) (b) W. E. Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sep. day 24 year 1940 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from 9-23, 1940, to 9-24, 1940, that I last saw him alive on 9-23-40, 19__, and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial Pneumonia — Duration

Due to: Senility & Gen weakness

Due to:

Other conditions: None
(Include pregnancy within 3 months of death)

Major findings:
Of operations: —

Of autopsy: no

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? No

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

23. Signature: B. F. Freeman (M. D. ~~or other~~)

Address: Springfield 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 Ogle Stone Jr., Registered Apprentice No. 232, working under my personal supervision.

Signed Warren D. Noblett

Licensed Embalmer No. 4005

P. O. Address Springfield 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.