

No. 2  
-13-40  
-17-39  
X23159

FEB 18 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **1213**  
Registrar's No. **173**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:  
(a) County **Jackson**  
(b) City or town **Kansas City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**346 N. Van Buren Blvd**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1**  
(Specify whether  
In this community **53 yrs**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **346 N. Van Buren Blvd**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. **0** years.

3. (a) PRINT FULL NAME **George Flemming Glenn**  
(b) If veteran, name war **no**  
(c) Social Security No. **no**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Jan** day **10**  
year **1941** hour **2** minute **50** P. M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex **male**  
5. Color or race **white**  
6. (a) Single, widowed, married, divorced **Married**  
(b) Name of husband or wife **Alma S. Glenn**  
(c) Age of husband or wife if alive **70** years  
7. Birth date of deceased **Dec 1 1958**  
(Month) (Day) (Year)

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

8. AGE: Years **82** Months **1** Days **9**  
If less than one day **9** hr. **0** min.

Immediate cause of death **Carcinoma of liver with metastases to lungs etc.**  
Due to **Cardiovascular Decomposition**  
Due to \_\_\_\_\_  
Other conditions **sinusitis**  
(Include pregnancy within 3 months of death)

9. Birthplace **Iowa**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Truck Man**  
11. Industry or business **Red Cooper Car Co**  
12. Name **Wm S. Glenn**  
13. Birthplace **Iud - 1**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Salenor Van East**  
15. Birthplace **Pa 1**  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

16. (a) Informant **Alma S. Glenn**  
(b) Address **346 N. Van Buren Blvd**  
17. (a) **Burial** (b) Date thereof **Jan - 13 '41**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Union Cem**  
18. (a) Signature of funeral director **Wm C. R. Foster**  
(b) Address **918 Brooklyn W.C. Mo**  
19. (a) **Jan 13 1941** (b) **M. M. Brown**  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) **no**  
(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 **3**  
23. Signature **P. J. DeMure M.D.** (M. D. or other)  
Address **1408 Malvern Rd** Date signed **Jan 41**

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

5-2

10-2-1914

Waldheim 11/10/14

11/6/105

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**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

*Sherald J. Wade*

Licensed Embalmer No. *417*

P. O. Address *J. C. B.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registrar's No. 173

Registration District No. ....

Primary Registration District No. ....

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

1. PLACE OF DEATH

(a) County Jackson K.C.  
(b) City or town K.C.  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether

In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME George F. Glenn

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

12. Name

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

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

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 1/13/41 (b) M. M. Crowe (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan. Day 14 Year 1941  
hour \_\_\_\_\_ minute \_\_\_\_\_ 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.

Immediate cause of death \_\_\_\_\_

carcinoma of face  
primary delusory  
met. to lungs etc.

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

53

S-1213