

*Dr Ed James*

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18109

State File No. ....

Registrar's No. *309*

LED JUN 10 1943

Registration District No. *136*

Primary Registration District No. *2801*

1. PLACE OF DEATH:

(a) County *Gasper*

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

Name of hospital or institution: *Neurony Home 4521 N. Wall*  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *1 week*  
(Specify whether)

In this community *40 years*  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Gasper*

(c) City or town *Gasper*  
(If outside city or town limits, write "RURAL")

(d) Street No. *706 N. Wall St*  
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country *0*

3. (a) PRINT FULL NAME *Lula M. Glover*

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *May* day *31*  
year *1943* hour *6* minute *45 P* M.

21. I hereby certify that I attended the deceased from *5-3* 19*43* to *5-31* 19*43*  
that I last saw her alive on *5-31-8 A.M.* 19*43*  
and that death occurred on the date and hour stated above.

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *2*

6. (b) Name of husband or wife *Levi O. Glover died July 14-1935* 6. (c) Age of husband or wife if *30*

7. Birth date of deceased *Sept 30 1866*  
(Month) (Day) (Year)

Immediate cause of death *Arteriosclerosis -*

Due to *Cardiac failure*

Due to *been ill long time*

Other conditions (Include pregnancy within 3 months of death) *932*

Major findings: Of operations ..... Of autopsy .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

8. AGE: Years *76* Months *8* Days ..... If less than one day hr. min.

9. Birthplace *Macon Co Mo*  
(City, town, or county) (State or foreign country)

10. Usual occupation *House work*

11. Industry or business *Wright*

12. Name *Wright*

13. Birthplace *no record*  
(City, town, or county) (State or foreign country)

14. Maiden name *no record*

15. Birthplace *no record*  
(City, town, or county) (State or foreign country)

16. (a) Informant *Mrs Joseph Dwyer*

(b) Address *706 N. Wall St*

17. (a) *Burial* (b) Date thereof *6-2-43*  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Mount Hope Cem*

18. (a) Signature of funeral director *Garbriel Deller*

(b) Address *Joplin Mo*

19. (a) *6-1-43* (b) *Edmund Sudholter*  
(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) .....

(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 *0*

23. Signature *Ed James* (M. D. or other) *0*

Address *Joplin Mo* Date signed *6-1-43*

*1204* (Licensed Embalmer's Statement on Reverse Side)

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

19  
2  
5

485-492

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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.....

*David Dillon*

Licensed Embalmer No.....

3898

P. O. Address.....

*Joplin, 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, fact should be so stated above.**