

FILED AUG 5 1943
Registration District No. 278

Primary Registration District No. 3054

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Louisa
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
114 North 8th
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 23 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike
(c) City or town Louisa
(If outside city or town limits, write "RURAL")
(d) Street No. 114 North 8th
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country USA

3. (a) PRINT FULL NAME Zoula Gladney

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if

7. Birth date of deceased. Jan 3 1895
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>4</u>	<u>29</u>hr.min.

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

10. Usual occupation.....

11. Industry or business At home

12. Name Ed H. Gladney

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

14. Maiden name Marta Mitchell

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

16. (a) Informant Mrs Ed H. Gladney

(b) Address Louisa Mo.

17. (a) Burial (b) Date thereof June 3 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mill Creek Cemetery

18. (a) Signature of funeral director James H. Thorne

(b) Address Louisa Mo.

19. (a) 6-3-43 (b) J. C. Kaley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2nd
year 1943 hour 9 minute A.M.

21. I hereby certify that I attended the deceased from Jan 1941 19..... to 6/2/43, 19.....
that I last saw her alive on 5/30/43, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia Duration 1 wk

Due to Chronic Myocarditis renal
" Arteritis Generalis tra
(non specific) "

Other conditions Malnutrition "

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?.....

While at work?..... (Specify type of place) (c) Means of injury.....

23. Signature Robert L. Andree (M. D. or other) Mo.

Address 216 Georgia St - Louisa Date signed 6/3/43

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 8-43-1218

Date Filed AUG 3 1943

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 J.B. Stone

Licensed Embalmer No. 4039

P. O. Address Louisiana M.

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.

RECEIVED
AUG 15 1943

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. UG 5 1943Registration District No. 270Primary Registration District No. 3057

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Pike
 (b) City or town Louisiana
 (If outside city or town limits, write "RURAL" and name of township)
 (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

Loula Gladney

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex

F5. Color or race W

6. (a) Single, widowed, married, divorced
- 5

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

min.

784

9. Birthplace _____

(City, town, or county)

(State or foreign country) MO.

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) _____ (Date received local registrar)

(b)

(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) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- June
- year
- 1943
- minute _____ M. _____

21. I hereby certify that I attended the deceased from _____, 19____; that I have seen him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: hypostatic bronchial pneumoniaDue to Chronic myocarditis" arthrititis generalDue to (non specific)Other conditions: malnutrition

(Include pregnancy within months of death)

Major findings: Coronary A. A. H.

Of operations: _____

Of autopsy: 93d

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? _____

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

23. Signature:
- Robert L. Audrae M.D.
- (M. D. or other)

Address Louisiana, MO. Date signed 8/9/43

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

SUPPLEMENTAL

S-25780