

FILED SEP 22 1943 160

Registration District No. _____ Primary Registration District No. 4385 Registrar's No. 44

1. PLACE OF DEATH: Dent
 (a) County _____
 (b) City or town Rural - Dent
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Station Hospital, Ft. Leonard Wood, Mo.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution DOA
 In this community Transient 3 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Glenn Robert Minton S/Sgt
 3. (b) If veteran, name war ----- 3. (c) Social Security No. -----

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Doris 6. (c) Age of husband or wife if alive ----- year (Month) (Day) (Year)

7. Birth date of deceased November 10 1921
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>22</u>	<u>9</u>	<u>26</u>	--- hr. --- min.

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

10. Usual occupation U.S. AAC 36531326

11. Industry or business Reeves Prov. GP-346 Bomb Gr.

MOTHER FATHER { 12. Name Robert Minton
 13. Birthplace Unknown (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant U.S. Army Records
 (b) Address Army Air Base, Dyersburg, Tenn.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 8, 1943 (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director W.E. Helman
 (b) Address Helman Mo

19. (a) Sept 7, 1943 (Date received local registrar) (b) Robert A Murray (Registrar's signature) Me

2. USUAL RESIDENCE OF DECEASED: 999 250
 (a) State Michigan (b) County Oakland
 (c) City or town Pontiac (If outside city or town limits, write "RURAL")
 (d) Street No. 29 S. Jessie (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 4 year 1943 hour about 4 minute 00 PM.

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 Multiple contusions, lacerations and fractures

Due to Airplane crash

Due to _____

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

Major findings: None Of operations _____

Of autopsy None

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) Accident 033

(b) Date of occurrence Sept. 4, 1943

(c) Where did injury occur? Rural Dent Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Rural--Airplane crash

While at work? Yes (Specify type of place) Airplane (e) Means of injury ground

23. Signature Robert A Murray (M. D. or other) 407

Address Ft. Leonard Wood, Mo. Date signed 4/17

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

1177

1943

RECEIVED
District Health Officer No. 5,
District File Number 943584
Date Filed 9-21-43

STATE BOARD
OF HEALTH
MEMPHIS, TENN.

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 myself, Registered Apprentice No. _____ working under my personal supervision.

Signed W. E. Holman
Licensed Embalmer No. 4107
P. O. Address Lebanon 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.

Registration District No. 110

Primary Registration District No. 5386

Registrar's No. 44

1. PLACE OF DEATH:

(a) County Cent
(b) City or town Rural - Meramec Range
(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) (Specify whether

3. (a) PRINT FULL NAME Glen Robert Minton Sr

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 _____

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

7. Birth date of deceased Nov. 10
(Month) (Day) (Year)

8. AGE: Years 22 Months 9 Days 26 If less than one day _____ min.

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 _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

31545