

FILED FEB 9 1944

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 60

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
6312 South 3rd St.
(If not in hospital or institution, write street number or location)

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

In this community 33 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary D. Glenn

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Warren W. Glenn

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

7. Birth date of deceased June 23, 1871
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>6</u>	<u>22</u>	hr. _____ min. _____

9. Birthplace Perry County Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name William D. Buckingham

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

14. Maiden name Almira McAllister

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

16. (a) Informant Warren W. Glenn

(b) Address 6312 So. 3rd St.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof Jan. 17, 1944
(Month) (Day) (Year)

(c) Place: burial or cremation Odd Fellows Cem.

18. (a) Signature of funeral director Carl Mortuary

(b) Address 5025 King Hill Ave.

19. (a) 1-17-44
(Date received local registrar)

(b) Use Keyoz
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri

(b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 6312 So. 3rd St.
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 15 year 1944 hour 1 minute 10 a. M.

21. I hereby certify that I attended the deceased from June 19, 1940 to Jan 15, 1944 that I last saw h. or alive on Jan 9, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion

Due to: Chr. myocarditis

Due to: Hypertensive arteriosclerosis
cardiovascular disease

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? _____

While at work? _____
(Specify type of place) (e) Month of injury _____

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

Address St. Joseph Mo Date signed 1-15-44

Duration 6 da.

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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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.....
Emma Clark

Licensed Embalmer No. *4235*

P. O. Address.....
H. Gray

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.