

Registration District No. 7 Primary Registration District No. 5033 Registrar's No.

1. PLACE OF DEATH:
(a) County Audrain
(b) City or town Rural.
(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 50 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Audrain
(c) City or town Rural.
(d) Street No.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Joseph Henry Gless
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 1 day 15 Ch year 1944 hour 9 minute 45 P.M.
21. I hereby certify that I attended the deceased from 1942 that I last saw him alive on Jan 15 1944 and that death occurred on the date and hour stated above.
Immediate cause of death

4. Sex Male race W
5. Color of hair
6. (a) Single, widowed, married divorced Married
6. (b) Name of husband or wife Anna Mary Gless
6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased June - 12 - 1871 (Month) (Day) (Year)

3 Cerebral Hemorrhage 1 day
Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

8. AGE: Years 71 Months 8 Days 3 If less than one day hr. min.

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

10. Usual occupation Retired Farmer
11. Industry or business Farming.

12. Name John Gless
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Anna Christina
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Gless
(b) Address Martinsburg Mo
17. (a) Burial (b) Date thereof 1-18-44 (Month) (Day) (Year)
(c) Place: burial or cremation Martinsburg

18. (a) Signature of funeral director J. P. Stoll
(b) Address Sikeville Mo
19. (a) Jan 17 1944 (b) Mary C. Jacobi (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?
(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 J. P. Stoll (M. D. or other) Address Sikeville Date signed 1-19-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 10

District File Number 2-44-440

Date Filed FEB 16 1944

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, ~~on~~.....

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

Signed A.B. Kelle.

Licensed Embalmer No. 1284

P. O. Address Wellsville.

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.