

FILED APR 17 1945

State File No. _____

Registration District No. 279

Primary Registration District No. 3056

Registrar's No. 55

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(c) Name of hospital or institution: 661 No Ault
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Moberly
(d) Street No. 661 No Ault
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charles Glynn

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

7. Birth date of deceased: Jan 19 1872
(Month) (Day) (Year)

8. AGE: Years 73 Months 2 Days 8 If less than one day hr. _____ min. _____

9. Birthplace: Mich. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

12. Name No data

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

14. Maiden name " 4

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

16. (a) Informant Mrs. Anna M Glynn

(b) Address Moberly, Mo

17. (a) Burial (b) Date thereof Mich 28 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly, Mo

18. (a) Signature of funeral director: Mahawandson

(b) Address Moberly Mo

19. (a) 3-29-45 (b) Anna
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27th
year 1945 hour _____ minute 30 P.M.

21. I hereby certify that I attended the deceased from June
_____, 1940 to March 26, 1945
that I last saw him in alive on March 26, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: broncho-pneumonia Duration 2 days

Due to Cerebral Hemorrhage 5 days

Due to Arteriosclerosis 2 yrs

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

Major findings: _____
Of operations: 830
Of autopsy: _____

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) _____

(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)
(2) Means of injury: 2

23. Signature: C.A. Stuyvenberg, D.O.
(M. D. or other)

Address: Jacksonville Mo Date signed: Mar 29 1945

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

663

1056

RECEIVED

District Health Officer No. 10

District File Number 4-45-627

Date Filed APR 13 1945

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 Frank D. Witt

Licensed Embalmer No. 3021

P. O. Address Moberly, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 294Primary Registration District No. 3056

Registrar's No.

1. PLACE OF DEATH: Randolph
 (a) County Randolph
 (b) City or town Merfeld
 (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 Charles Lynn

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 m

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

7. Birth date of deceased Jan 19
(Month) (Day) (Year)8. AGE: Years 73 Months 2 Days 4 (If less than one day, min.)9. Birthplace Mich
(City, town, or county) (State or foreign country)

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.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b) Prima Tave
(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 mar day 7
year 1945 hour..... minute..... M.21. I hereby certify that I attended the deceased from..... 19.....;
that I last saw him..... alive on..... 19.....;
and the 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

14357