S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

32983

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 18 1945

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 1 Primary Registration District No. ~~3000~~ 4001 Registrar's No. 218

**1. PLACE OF DEATH:**

(a) County Adair

(b) City or town Novinger, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Home, Novinger, Missouri 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether
In this community Life
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Adair 1

(c) City or town Novinger 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Gary LaVerne Glaspie

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex m 0

5. Color or race white

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 3 (Day) 1945 (Year)

8. AGE: Years 4 Months 4 Days 11 If less than one day hr. min.

9. Birthplace Novinger, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Leo Glaspie
13. Birthplace Adair Co. Missouri 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Celesta Knox
15. Birthplace Unknown Iowa 1
(City, town, or county) (State or foreign country)

16. (a) Informant Leo Glaspie
(b) Address Novinger, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/45 (Month) (Day) (Year)
(c) Place: burial or cremation Novinger, Missouri

18. (a) Signature of funeral director D E Riley
(b) Address Kirksville, Mo.

19. (a) 9-25-45 (Date received local registrar) (b) Mrs. J. L. Waguri (Registrar's signature)

1614

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month September day 17th year 1945 hour minute M.

21. I hereby certify that I attended the deceased from September 17, 1945, to ----------, 19 ; that I last saw him alive on September 17, 1945; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Infectious Diarrhaea | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations 119w | |
| 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?
(Specify type of place)

While at work? (e) Means of injury 0

23. Signature E. S. Smith (M. D. or other)

Address Kirksville Date signed 9/18/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-45-1546
Date Filed OCT 17 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 D E Riley

Licensed Embalmer No. 4181

P. O. Address Kirkville 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.**