

Registration District No. 199

Primary Registration District No. 1002

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 months
(Specify whether years, months or days)
 In this community 5 years

3. (a) PRINT FULL NAME Charlie Grant GLAZE
 3. (b) If veteran, name war 70
 3. (c) Social Security No. none

4. Sex Male
 5. Color or race White
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Mrs. Letha Glaze
 6. (c) Age of husband or wife if alive 79 years
 7. Birth date of deceased October 25 1872
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>6</u>	<u>22</u>	hr. min.

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

10. Usual occupation Retired

11. Industry or business Carpenter

12. Name Eliza Glaze

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

14. Maiden name Amanda H. Hallen

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

16. (a) Informant Mrs. Letha Glaze

(b) Address 4315 Spruce Avenue

17. (a) Removal Removal (b) Date thereof May 18 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Carthage Illinois

18. (a) Signature of funeral director D. H. Thurmon's Sons

(b) Address 1401 Brush Creek Blvd

19. (a) 5-17-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits write "RURAL")
 (d) Street No. 4315 Spruce Avenue
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 17
 year 1947 hour _____ minute _____ M.

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

Immediate cause of death acute cardiac dilatation
 Due to Encephalomalacia - chronic cellulitis rt. hip.
 Due to fracture - complete - right femur
 Other conditions Diabetes mellitus.
(Include pregnancy within 3 months of death)

Major findings:
 Of operations 186 a
 Of autopsy above 10

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) accident? A. 3
 (b) Date of occurrence 8 weeks ago
 (c) Where did injury occur? K. C. Jackson, Mo.
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home
(Specify type of place)
 While at work? no (e) Means of injury fall
 23. Signature J. L. Stuebel (M. D. or other) M.D.
 Address Trinity Lutheran Hosp Date signed 17 May 47

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

Carl Bunt

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 *Melvin Miller*

Licensed Embalmer No. *4407*

P. O. Address *Kansas City 3, 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.