

No. 2
2-45
17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 9 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19702**

Registration District No. **317**

Primary Registration District No. **6876**

Registrar's No. **1066**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Lemay**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Mt. St. Rose Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 months**
(Specify whether
In this community **All his life**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Kirkwood**
(If outside city or town limits, write "RURAL")
(d) Street No. **216 N. Kirkwood Rd**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Borrromeo Chas. Glacken**

3. (b) If veteran, name war
3. (c) Social Security No. **492-10-7222**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Geraldine**
6. (c) Age of husband or wife if alive **40** years
7. Birth date of deceased **Nov. 4 1897**
(Month) (Day) (Year)

8. AGE: Years **49** Months **6** Days **18**
If less than one day hr. min.

9. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Locker Room Attendant**

11. Industry or business **Sunset Country Club**

12. Name **Wm. Glacken**
13. Birthplace **St. Louis County Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Margaret Hartnett**
15. Birthplace **St. Louis County Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Geraldine Glacken**
(b) Address **216 N. Kirkwood Rd.**

17. (a) **Burial** (b) Date thereof **5/26/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Central Cem.**

18. (a) Signature of funeral director **Louis H. Bopp, Inc.**
(b) Address **131 W. Argonne Dr. Kirkwood**

19. (a) **5-27-47** (b) **Carole J. [Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **22**
year **1947** hour **7** minute **55 A.M.**

21. I hereby certify that I attended the deceased from **9-22 1946** to **5-22 1947**
that I last saw him alive on **5-19 47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis**
Duration **several years?**
Due to **138**

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 **Paul [Signature]** (M. D. or other)
Address **535 N. Grand St. [Signature]** Date signed **5-20-47**

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

DEC 19 1950

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..... *Felix Durand*

Licensed Embalmer No. *3034*

P. O. Address *Kirkwood (22)*

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.