No. 2
12-45
-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 8 1947

Registration District No. 42

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1000

State File No. 20132

Registrar's No. 788

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Methodist Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 day (Specify whether years, months or days)
In this community: 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Buchanan

(c) City or town: St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No.: 209½ Southth 13th St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Ruben Glaser

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife:

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

7. Birth date of deceased: June (Month) 22 (Day) 1947 (Year)

8. AGE: Years 0 | Months 0 | Days 1 | If less than one day: hr. min.

9. Birthplace: St. Joseph, (City, town, or county) Missouri. (State or foreign country)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Julius Glaser
13. Birthplace: Kansas City, (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name: Bessie Rothman
15. Birthplace: St. Joseph (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Jarline Glaser
(b) Address: 209½ So.13th. St., St.Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6/24/ 1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Shaare Sholem Cemetery

18. (a) Signature of funeral director: Walter Meierhofer
(b) Address: 1946 Colhoun St., St. Joseph, Mo.

19. (a) 6-28-47 (Date received local registrar) (b) E. L. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23, year 1947 hour 5 minute 20 p. M.

21. I hereby certify that I attended the deceased from 6-22-47, 19__, to 6-23-47, 19__; that I last saw him alive on 6-23-47, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: Prematurity

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death): 159

Major findings: Of operations:

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) (e) Means of injury:

23. Signature: H. C. Peterson (M. D. ~~or other~~)

Address: 6-24-47 Date signed: 6/24

(Licensed Embalmer's Statement on Reverse Side) St. Joseph, Mo 620 Francis

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 George Kingbermuehle, Registered Apprentice No. 508, working under my personal supervision. or Was not embalmed

Signed Foster Meierhoffer Jr.

Licensed Embalmer No. 14244

P. O. Address St. Joseph, Missouri.

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.