

No. 2
2-43
1-17-39
X35897

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8713
Registrar's No. 1181

FILED MAR 27 1948
Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town K.C. Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Gross Nursing Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 MO. (Specify whether
In this community 28 years years, months or days)

3. (a) PRINT Mrs. Ida Glueck
FULL NAME
3. (b) If veteran. No name war
3. (c) Social Security No. No

4. Sex Female / 5. Color or race Wh.
6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife A. P. Glueck
6. (c) Age of husband or wife if alive 16 years 1864

7. Birth date of deceased. Aug. 16 1864
(Month) (Day) (Year)

8. AGE: 83 Years 6 Months 29 Days
If less than one day hr. min.

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

10. Usual occupation Home

11. Industry or business No

12. Name Unknown 9

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

14. Maiden name Unknown

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant M. A. Glueck (Son)
(b) Address 1401 W. 50 St. Terrace

17. (a) Removal (b) Date thereof 30 16 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salina Ks

18. (a) Signature of funeral director Stine & McClure
(b) Address K. C. Mo.

19. (a) 3-16-48 (b) Sheldine Holme
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson 48
(c) City or town Kansas city 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1401 W. 50 St. Terrace 8
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15
year 1948 hour 5 minute 50 AM M.

21. I hereby certify that I attended the deceased from 1940
19. to March 15 1948
that I last saw her alive on March 14 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis Duration 2 1/2 days

Due to Generalized Arteriosclerosis 10+ yrs.

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 83 15
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 Harold M. Roberts (M. D. or other) M.D.
Address 1103 Grand, K.C., Mo. Date signed 3-16-48

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

8

Dr. Harold Roberts
Prof. Bldg.

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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address Mc. 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.