

No. 2  
2-45  
17-39  
X47070

FILED NOV 1 1948

Registration District No. **42** Primary Registration District No. **1000**

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

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:  
2119 South Sixth Street  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community most of life  
years, months or days

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. 2119 So. 6th Street  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sara Charlotte Coffey Glaze

3. (b) If veteran, name war none

3. (c) Social Security No. 491-28-6359

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 14th  
year 1948 hour Six minute Thirty AM

21. I hereby certify that I attended the deceased from Oct 13 1948  
\_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

that I last saw her alive on Oct 13  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife James Glaze

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased July 12th 1897  
(Month) (Day) (Year)

Immediate cause of death Pulmonary tuberculosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>51</u>	<u>3</u>	<u>2</u>	hr. _____ min.

9. Birthplace New Market, Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Frank Duncan

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

14. Maiden name Charlotte Chaney

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

Major findings: Of operations 13B

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Faith Vandervort

(b) Address 2132 So. 7th St., St. Joseph, Mo.

17. (a) Burial (b) Date thereof Oct. 16, 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director E. R. Ridenfaden

(b) Address 602 So. 10th St.

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 \_\_\_\_\_

19. (a) 10-27-48 (b) H. C. Jenkins  
(Date received local registrar) (Registrar's signature)

23. Signature J. M. Cameron M.D. or other \_\_\_\_\_  
Address 2207 S. 31st Street Date signed Oct 14, 1948

**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 *Mollie E. Sidenfaden*

Licensed Embalmer No. *4235*

P. O. Address *St. Joseph, 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.**