

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

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34937  
Registrar's No. 2222

FILED OCT 23 1948  
Registration District No. 1487

Primary Registration District No. 3065

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Kirkwood Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
421 SO HARRISON  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME TAYLOR GLENN JR.  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race Col 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife PAULENA GLENN 6. (c) Age of husband or wife if alive 71 years  
7. Birth date of deceased DEC 25 1881  
(Month) (Day) (Year)

8. AGE: Years 66 Months 8 Days 28  
If less than one day: hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country) MISS.

10. Usual occupation LABOR.

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

MOTHER FATHER  
12. Name TAYLOR GLENN  
13. Birthplace MISS.  
(City, town, or county) (State or foreign country)  
14. Maiden name SARAH  
15. Birthplace MISS.  
(City, town, or county) (State or foreign country)

16. (a) Informant PAULENA GLENN

(b) Address 421 SO HARRISON

17. (a) BURIED (b) Date thereof SEPT 25 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Father Jackson

18. (a) Signature of funeral director F. A. GREEN

(b) Address 4214 PALM BLVD

19. (a) 9133-48 (b) Glenn Jackson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO County 96  
(c) City or town Kirkwood MO  
(If outside city or town limits, write "RURAL")  
(d) Street No. 421 SO HARRISON ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month SEPT day 21  
year 1948 hour 4 minute P M.  
21. I hereby certify that I attended the deceased from 8:10 20  
1948 to SEPT 22 1948  
that I last saw him alive on Sept 27 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Duration 7 hrs.

Due to \_\_\_\_\_  
Due to 9:30

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 W. S. Ward (M. D. or other) MD

Address Kirkwood Mo Date signed 9/23/48

**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

*J. G. Green*

Licensed Embalmer No

*2963*

P. O. Address

*4214*

**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.**