

FILED JUN 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18952

BIRTH NO. 14712-49 REG. DIST. NO. 72 PRIMARY REG. DIST. NO. 5289 Registrar's No. 63

249

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

1. PLACE OF DEATH a. COUNTY Clay Rural Gallatin Twp.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE Missouri b. COUNTY Clay	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maple Park Gardens		c. LENGTH OF STAY (In hospital) OR TOWN Maple Park Gardens	
d. FULL NAME OF HOSPITAL OR INSTITUTION Whitman Avenue		d. STREET ADDRESS (If rural, give location) Whitman Avenue	

3. NAME OF DECEASED (Type or Print)	a. (First) Marva	b. (Middle) Sue	c. (Last) Glendening	4. DATE OF DEATH (Month) (Day) (Year) June 9, 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH Feb. 28, 1949	9. AGE (In years last birthday) 3 IF UNDER 1 YEAR II IF UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Kansas City, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Clinton Earl Glendening Jr.	13b. MOTHER'S MAIDEN NAME Yvonne Cathcart	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. C.E. Glendening Jr. Maple Park
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) meningitis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Splenic infarct & large hemorrhage DUE TO (c) Acquired malformation since birth.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hydrocephalus -		3403	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Feb 28, 1949**, to **June 9, 1949**, that I last saw the deceased alive on **June 1, 1949**, and that death occurred at **10:30 P.M.** from the causes and on the date stated above.

23a. SIGNATURE (Name of title) William L. ...	23b. ADDRESS 2025 ...	23c. DATE SIGNED 6-10-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 11, 1949	24c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	24d. LOCATION (City, town, or county) (State) Liberty, Mo.
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DATE REC'D BY LOCAL REG. June 11-49	REGISTRAR'S SIGNATURE Beulah Kitchener	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Liberty, Mo.
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RECEIVED

District H.

District File #

Date Filed

No. 8
6-27-47

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 _____

Student Embalmer No. _____

~~working under my personal supervision.~~

Student
Student Embalmer

Signed

[Handwritten Signature]

Licensed Embalmer No. 3934

P. O. Address. Liberty, 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.