FILED JUN 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20606

BIRTH NO. _____ REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 3056 Registrar's No. 135

1. PLACE OF DEATH
a. COUNTY: Randolph
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moberly
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 535 No Ault

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Randolph
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moberly
d. STREET ADDRESS (If rural, give location): 535 No Ault

3. NAME OF DECEASED (Type or Print)
a. (First): Marion
b. (Middle):
c. (Last): Glydewell

4. DATE OF DEATH (Month) (Day) (Year): June 22 1949

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: July 3rd 1918
9. AGE (In years last birthday): 30 — If under 1 year: Months 11, Days 18 — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mo
12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: Earl Glydewell
13b. MOTHER'S MAIDEN NAME: Estella Mayfield
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Mrs Estella McCollum — ADDRESS: Moberly

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

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Natural — Undetermined — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Sick mind
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

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19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

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):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* 8:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Thos. E. Barnes Coroner
23b. ADDRESS: Moberly Mo
23c. DATE SIGNED: June 28-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 25-49
24c. NAME OF CEMETERY OR CREMATORY: Oakland
24d. LOCATION (City, town, or county) (State): Moberly Mo

DATE REC'D BY LOCAL REG.: 6-24-49
REGISTRAR'S SIGNATURE: Leah Unerman Local Reg.
25. FUNERAL DIRECTOR'S SIGNATURE: Mahan and Son — ADDRESS: Moberly Mo

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer N
District File Number 6-49-
Date Filed JUN 27 1949

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 Frank D. Hill

Licensed Embalmer No. 3021

P. O. Address Moberly, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.