

FILED JUN 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21061**

BIRTH NO. **30661-49** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5180**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY ADO	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN ST. LOUIS MO)		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS MO	
c. LENGTH OF STAY (In this place) 6 wks		d. STREET ADDRESS (If rural, give location) 5377 Thebes	
d. FULL NAME OF HOSPITAL OR INSTITUTION De PAUL Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) DENIS b. (Middle) ALBERT c. (Last) GLORIOD			4. DATE OF DEATH (Month) (Day) (Year) JUNE 14, 1949		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH MAY 4, 1949	9. AGE (In years last birthday) 1	10. IF UNDER 1 YEAR Months 1 Days 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MISSOURI MO	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME PAUL GLORIOD		13b. MOTHER'S MAIDEN NAME CECLIA DOVEN		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT'S SIGNATURE OR NAME Paul Gloriod ADDRESS. 5377 Thebes	

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, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cirrhosis of liver		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) Undetermined		6 wks.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) Prematurity			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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) 109 77 BX	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **5/5, 1949**, to **6/14, 1949**, that I last saw the deceased alive on **6/13, 1949**, and that death occurred at **10:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Jackson Sr. M.D.		23b. ADDRESS 734 Motheatre Bldg		23c. DATE SIGNED 6/14/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/15/49		24c. NAME OF CEMETERY OR CREMATORY St. Stephens	
24d. LOCATION (City, town, or county) (State) Richwoods, MO		25. FUNERAL DIRECTOR'S SIGNATURE Casey & Russell St. Clair, Mo ADDRESS			
DATE REC'D BY LOCAL REG. JUN 14 1949		REGISTRAR'S SIGNATURE J. B. Laster			

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

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 _____

working under my personal supervision.

Signed.....
Student Embalmer



Student Embalmer No. _____

Signed Embalmed
James E. [unclear]

Licensed Embalmer No. 4520

P. O. Address St. Clair, 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.