

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7400**

APR 15 1952

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **368**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give townships) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
c. LENGTH OF STAY (in this place) 17 yrs.		d. STREET ADDRESS (If rural, give location) 904 S. Noyes Blv'd.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Helen	b. (Middle) Lorraine	c. (Last) Glidewell	4. DATE OF DEATH (Month) (Day) (Year) April 3, 1952.
-------------------------------------	-------------------------	-----------------------------	----------------------------	---

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH February 9, 1917	9. AGE (in years last birthday) 35	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
----------------------	-------------------------------	---	--	---	------------------------	-----------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Gilford, Missouri.	12. CITIZEN OF WHAT COUNTRY? USA
--	--	---	---

13a. FATHER'S NAME William Campbell	13b. MOTHER'S MAIDEN NAME Selma Nelson	14. NAME OF HUSBAND OR WIFE George J. Glidewell
--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY (If yes, give no. or date of service) 91-09-2962	17. INFORMANT'S SIGNATURE OR NAME George J. Glidewell	ADDRESS St. Joseph, Mo.
---	---	--	--------------------------------

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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH ONE WEEK
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MULTIPLE HEMORRHAGES OF BRAIN		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. PANCYTOPENIA TOXIC DEPRESSION OF BONE MARROW, CAUSE UNDETERMINED		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	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 **7/3/51**, 19____, to **4/3/52**, 19____, that I last saw the deceased alive on **4/2/52**, 19____, and that death occurred at **3:15 A.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Allen Spahrman M.D.	23b. ADDRESS 706 Francis	23c. DATE SIGNED 4-4-52
---	---------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Apr. 5, 1952	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri.
---	-------------------------------	--	--

DATE REC'D BY LOCAL REG. April 9, 1952	REGISTRAR'S SIGNATURE Carl C. [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Walter [Signature]	ADDRESS St. Joseph, Mo.
---	--	--	--------------------------------

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

117
0

APR 25 1952

APR 16 1952

APR 28 1952

MAY 22 1952

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.

Student Embalmer No.****

Signed

Raymond H. Morehead

Signed.....**** Student Embalmer

Licensed Embalmer No. 4413 Missouri

P. O. Address St. Joseph, Missouri.

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.