

FILED OCT 3 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31446

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Howell			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Howell		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WEST PLAINS		c. LENGTH OF STAY (In this place) 4 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN W. Plains		0461
d. FULL NAME OF HOSPITAL OR INSTITUTION CHRISTA HOGAN HOSP.			d. STREET ADDRESS (If rural, give location) 1025 Woodland.		
3. NAME OF DECEASED (Type or Print) a. (First) ROBERT		b. (Middle) DENNIS		c. (Last) GLEASON	
4. DATE OF DEATH (Month) (Day) (Year) SEPT. 24, 1952		5. SEX male		6. COLOR OR RACE white	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH DEC. 17, 1905		9. AGE (In years last birthday) 46	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WOODWARD Co., OKLA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Chas. Gleason		13b. MOTHER'S MAIDEN NAME	
14. NAME OF HUSBAND OR WIFE Korena Mae Millard Gleason		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 481-03-9882	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Robt. D. Gleason, W. Plains, Mo.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 30 MIN.	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Hypertensive Cardiovascular renal disease 7 yrs.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201		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) (Minute)		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 7-30, 1952 to 9-24, 1952 , that I last saw the deceased alive on 9-24, 1952 , and that death occurred at 3:00 p.m. , from the causes and on the date stated above.					
23a. SIGNATURE C. Callahan M.D. (Degree or title)		23b. ADDRESS WEST PLAINS, Mo.		23c. DATE SIGNED 9-27-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) B. U		24b. DATE 9-26-52		24c. NAME OF CEMETERY OR CREMATORY Oak Lawn	
24d. LOCATION (City, town, or county) (State) West Plains Mo		DATE REC'D BY LOCAL REG. 9-29-52		REGISTRAR'S SIGNATURE Beatrice Cook	
25. FUNERAL DIRECTOR'S SIGNATURE Hal Thompson		ADDRESS			

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

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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, ~~and~~ by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Hal Thompson

Licensed Embalmer No. 3408

P. O. Address West Plains,

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.