

0.300
0.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27782**

FILED SEP 8 - 1953

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **949**

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 township) St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) St. Joseph 0117	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2607 So. 28th St.		d. STREET ADDRESS (If rural, give location) 2607 So. 28th St.	

3. NAME OF DECEASED (Type or Print) a. (First) Robert	b. (Middle) A	c. (Last) Gloggner	4. DATE OF DEATH (Month) (Day) (Year) Aug. 29, 1953
---	----------------------	---------------------------	---

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 25, 1885	9. AGE (In years last birthday) 67	10 UNDER 1 YEAR Months	10 UNDER 1 YEAR Days	10 UNDER 1 YEAR Hours	10 UNDER 1 YEAR Min.
--------------------	-------------------------------	---	---------------------------------------	---	------------------------	----------------------	-----------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (5) machinist	10b. KIND OF BUSINESS OR INDUSTRY St. C.B.&.Q RR	11. BIRTHPLACE (City and State or Foreign Country) St. Joseph, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	--	---	--

13a. FATHER'S NAME Joseph Gloggner	13b. MOTHER'S MAIDEN NAME Walburga Hockenauer	14. NAME OF HUSBAND OR WIFE Frances Gloggner
--	---	--

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. 707-05-8745	17. INFORMANT'S SIGNATURE OR NAME Mrs R.A. Gloggner	ADDRESS City 2607 So 28th St.
---	---	---	---

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 12/5/53
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral embolism		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Paternal		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. As cited		6/53	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 5810	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)	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 **12/5** to **8/29**, 19**53**, that I last saw the deceased alive on **8/24**, 19**53**, and that death occurred at **4:58** p.m., from the causes and on the date stated above.

23a. SIGNATURE Frank Nardyan, MD	(Degree or title)	23b. ADDRESS 620 Francis St. City	23c. DATE SIGNED 8/31/53
--	-------------------	---	------------------------------------

24a. BURIAL, CREMATION, REMOVAL Burial	24b. DATE 9-1-53	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
--	----------------------------	--	---

DATE REC'D BY LOCAL REG. Sept 2, 1953	REGISTRAR'S SIGNATURE Kathleen M. Allison	485	25. FUNERAL DIRECTOR'S SIGNATURE Human... Bedenfadn	ADDRESS 1802 Union St. St. Joseph, Mo.
---	---	-----	---	--

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 9 1953

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 Robert H. Gaper

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.