

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2814

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** State File No. _____ Registrar's No. **0331**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (In this place) 2 1/2 yrs		d. IS RESIDENCE WITHIN LIMITS OF A CITY OR INCORPORATED TOWN? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Joseph DeL. Old Froch Home			e. STREET ADDRESS (If rural, give location) 1438 E Grand		
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		5. SEX
a. (First)	b. (Middle)	c. (Last)	Month	Day	Year
Joe	(AKA SHULGLASS)	GLASS	JAN	13	1954
6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years less birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
White	wid	unk	ab 73	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country)		12. CITIZEN OF WHAT COUNTRY	
Teacher		USSR		unk	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
unk		unk		unk	
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 ADDRESS	
unk		None		B. Kufeld 1438 E Grand	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)			Lymphosarcoma, mediastinal			of mos
*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			
ANTECEDENT CAUSES			DUPLICATE TO (b)			
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			DUPLICATE TO (c)			
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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, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No. 452

P. O. Address

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**