

FILED AUG 18 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27298**
3479

BIRTH NO. **1367088912-54** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **3479**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	c. LENGTH OF STAY (In this place) 2 Mos.	c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION General Hospital # 2		e. STREET ADDRESS (If rural, give location) 1412 Park 3233	

3. NAME OF DECEASED (Type or Print)	a. (First) John	b. (Middle) Henry	c. (Last) Glenn	4. DATE OF DEATH (Month) (Day) (Year) July 14, 1954
-------------------------------------	------------------------	--------------------------	------------------------	---------------------------------------------------------------

5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH Nov. 21, 1953	9. AGE (In years last birthday) 7	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
--------------------------------	----------------------------------	--------------------------------------------------------------------------------	------------------------------------------	------------------------------------------	-------------------------------------------	--------------------------------

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 (City and State or Foreign Country) Kansas City, Mo	12. CITIZEN OF WHAT COUNTRY? US
-------------------------------------------------------------------------------------------------------------	--------------------------------------------------	------------------------------------------------------------------------------	-------------------------------------------

13a. FATHER'S NAME Oliver Campbell	13b. MOTHER'S MAIDEN NAME Vera Lee Glenn	14. NAME OF HUSBAND OR WIFE NONE
----------------------------------------------	----------------------------------------------------	--------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Vera Lee Glenn	ADDRESS 600 E. 22nd 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Interstitial pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		52	

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 **7-13-** **1954** to **7-14-** **1954**, that I last saw the deceased alive on **7-14-** **1954**, and that death occurred at **12:45** m., from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title) MD	23b. ADDRESS 600 E. 22nd St.	23c. DATE SIGNED
--------------------------------------	--------------------------------	----------------------------------------	------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BUR	24b. DATE 7/20/54	24c. NAME OF CEMETERY OR CREMATORY Highland	24d. LOCATION (City, town, or county) (State) K. C. Mo
---------------------------------------------------------	-----------------------------	-------------------------------------------------------	------------------------------------------------------------------

DATE REC'D BY LOCAL REG. 7-19-54	REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Bright & Jones	ADDRESS 1001 1/2 St.
--------------------------------------------	-------------------------------------------------	---------------------------------------------------------------	--------------------------------

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
E. Frank Ellis MD

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.....

P. O. Address.....

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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.

If this body is not embalmed, fact should be so stated above.