

FILED OCT 4 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29847

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 1030	
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 OR TOWN St. Joseph		c. LENGTH OF STAY (In this place) 15 years		c. CITY OR TOWN St. Joseph		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 Missouri Methodist Hospital				e. STREET ADDRESS (If rural, give location) 2907 Sacramento St. 0117 0			
3. NAME OF DECEASED (Type or Print) Cecil W. Glassel			4. DATE OF DEATH (Month) (Day) (Year) Sept. 19, 1954				
5. SEX <input checked="" type="checkbox"/> male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH September 25, 1900	
9. AGE (In years last birthday) 53		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director of Education		11. BIRTHPLACE (City and State or Foreign Country) Valley Falls, Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director of Education		10b. KIND OF BUSINESS OR INDUSTRY Dannen Mill, Inc.		11. BIRTHPLACE (City and State or Foreign Country) Valley Falls, Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Jesse L. Glassel			13b. MOTHER'S MAIDEN NAME Bessie A. Robertson			14. NAME OF HUSBAND OR WIFE Dora	
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. 493-18-1300		17. INFORMANT'S SIGNATURE OR NAME Mrs. Dora Glassel, 2907 Sacramento, 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) THROMBOSIS, LEFT CEREBELLAR VESSELS  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. -----					INTERVAL BETWEEN ONSET AND DEATH 5 DAYS
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION NONE			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	
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)	
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? NONE			
22. I hereby certify that I attended the deceased from SEPT 13, 1954, to SEPT 19, 1954, that I last saw the deceased alive on SEPT 18, 1954, and that death occurred at 6:30 a. m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>Allan L. Sherman</i> M.D.				23b. ADDRESS 706 FRANCIS ST. ST. JOSEPH, Mo.		23c. DATE SIGNED 9-20-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 9/22/1954		24c. NAME OF CEMETERY OR CREMATORY Valley Falls, Kansas		24d. LOCATION (City, town, or county) (State) Valley Falls, Kansas	
DATE REC'D BY LOCAL REG. Sept. 27, 1954		REGISTRAR'S SIGNATURE <i>Kathleen M. Allison</i> 485		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Hester - Bowman - St. Joseph, Mo.</i>			

(Licensed Embalmer's Statement on Reverse Side)

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

---

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 *Eugene Wood*.....

Licensed Embalmer No. *3804*.....

P. O. Address *319 South St.*.....

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.