

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3871**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **208**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Nemaha</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Joseph</b> )		c. CITY OR TOWN <b>Centralia</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>2 months</b>		e. STREET ADDRESS (If rural, give location) <b>815<sup>0</sup> 8</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3203 Lafayette St.</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>LURANNAH</b>	b. (Middle) <b>JANE</b>	c. (Last) <b>GLANCY</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 16, 1956</b>
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>August 26, 1876</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Centralia, Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Grandful Hales</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Jane Lane</b>	14. NAME OF HUSBAND OR WIFE <b>Jackson P. Glancy</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Glen Glancy, 3203 Lafayette, St. Joseph, Mo.</b>	ADDRESS
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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 <b>24 hrs</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>		
	ANTECEDENT CAUSES DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Tumor of uterus</b> <b>Senility</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <b>Centralia, Kansas</b>
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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?
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22. I hereby certify that I attended the deceased from **1-30, 1956** to **2-16, 1956**, that I last saw the deceased alive on **2-16, 1956**, and that death occurred at **6:45 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>St. Grant M.D.</b>	(Degree or title) <b>St. Joseph, Mo</b>	23b. ADDRESS	23c. DATE SIGNED <b>2.21.56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24b. DATE <b>2/17/1956</b>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <b>Centralia, Kansas</b>
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DATE REC'D BY LOCAL REG. <b>Feb 28, 1956</b>	REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Heaton-Bowman - St. Joseph, Mo.</b>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

FILED MAR 5 1956

*9/11/17*

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.....  
*Richard D. Collins*

Licensed Embalmer No. *495*  
*319 So. 10th St*  
P. O. Address.....  
*St. Joseph*

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.