

FILED MAR 22 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **10765**
2166REG. DIST. NO. **318**PRIMARY REG. DIST. NO. **1003**

Registrar's No. _____

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
ST. LOUIS				ST. LOUIS					
d. FULL NAME OF HOSPITAL OR INSTITUTION				e. STREET ADDRESS (If rural, give location)					
CITY HOSPITAL				25 815 Franklin 225/0					
3. NAME OF DECEASED (Type or Print)			a. (First)		b. (Middle)		c. (Last)		
NATHANIEL			D.		GLASCOCK		4. DATE OF DEATH (Month) (Day) (Year)		
							February 29, 56		
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White		Divorced		12-14-1882		73	
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?	
Cook			Retired			Ross Co. Missouri		U.S.A.	
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE			
Richard Glascock			Anna Davis			Betty			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)			16. SOCIAL SECURITY NO.			17. INFORMANT'S SIGNATURE OR NAME ADDRESS			
No			494-09-7767			Jasper C. Glascock, Hanibal, Mo			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)				INTERVAL BETWEEN ONSET AND DEATH	
				MEDICAL CERTIFICATION <i>Cerebral Apoplexy</i>					
				ANTECEDENT CAUSES					
*This does not mean the mode of dying, such as heart failure, athenia, etc. It means the disease, injury, or complication which caused death.				DUE TO (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.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		334x							
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) (Min.)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:50 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE				23b. ADDRESS				23c. DATE SIGNED	
<i>James M Kelly</i>				1300 Clark				3-1-56	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORIUM		24d. LOCATION (City, town, or county) (State)			
Removal		3-2-1956		St. Trinity Lutheran		St. Louis County, Mo.			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				
MAR 1 1956		<i>J. Carl Smith MS</i>			McLAUGHLIN F.H., INC. 2301 Lafayette				

(Licensed Embalmer's Statement on Reverse Side)

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

300
48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *L. R. Cooper*

Licensed Embalmer No..... *367*

P. O. Address..... *2301 Lafayette*

- Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.