

FILED APR 2 1956

STANDARD CERTIFICATE OF DEATH

State File No. 10768

BIRTH NO. 1116-56 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2905

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Dent	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Salem	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital		d. STREET ADDRESS (If rural, give location) 033/1	
3. NAME OF DECEASED (Type or Print) a. (First) Ricky b. (Middle) Dale c. (Last) Glenn			4. DATE OF DEATH (Month) (Day) (Year) March 20, 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Jan. 16, 1956
9. AGE (In years last birthday) 10		10. KIND OF BUSINESS OR INDUSTRY Infant	11. BIRTHPLACE (City and State or Foreign Country) Salem, Mo.
12. CITIZENRY OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME William E. Glenn	
13b. MOTHER'S MAIDEN NAME Betty Snider		14. NAME OF HUSBAND OR WIFE None	
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. None	
17. INFORMANT'S SIGNATURE OR NAME Mrs. John Glenn		ADDRESS 5848 Cabanne Ave.	
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) Congenital heart disease Congenital heart disease Antecedent causes Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cystic type - Cystic type 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 Pulmonary atresia 754.4	
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) 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 March 18, 1955 to March 20, 1956, that I last saw the deceased alive on 3-20, 1956 and that death occurred at 6:20 p. m., from the causes and on the date stated above.			
23a. SIGNATURE M.C. Gerstman, D. (Degree or title)		23b. ADDRESS 8700 Riverside	
23c. DATE SIGNED 3/21/56			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3-21-56	
24c. NAME OF CEMETERY OR CREMATORY Local		24d. LOCATION (City, town, or county) (State) Salem, Mo.	
DATE REC'D BY LOCAL REG. MAR 21 1956		REGISTRAR'S SIGNATURE J. Carl Smith M.D. (Licensed Embalmer's Statement on Reverse Side)	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	

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
Student Embalmer

Signed

Robert M. Murray

Licensed Embalmer No. *3749*

P. O. Address *St. Louis Mo*

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