

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15852**

FILED JUN 4 1956 REG. DIST. NO. **75** PRIMARY REG. DIST. NO. **3015** Registrar's No. **60**

1. PLACE OF DEATH a. COUNTY Clinton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Clinton	
b. CITY OR TOWN Cameron	c. LENGTH OF STAY (If this place) LIFE	c. CITY OR TOWN Cameron	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 Cameron Hosp.		e. STREET ADDRESS (If rural, give location) 0250	

3. NAME OF DECEASED (Type or Print) a. (First) John M. Glessana b. (Middle) Divinia c. (Last) Divinia			4. DATE OF DEATH (Month) (Day) (Year) May-19-1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH April 22 1863	9. AGE (In years) 93	10. MONTHS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and State or Foreign Country) Calwell Co. Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME John G. Divinia		13b. MOTHER'S MAIDEN NAME Sarah Robertson		14. NAME OF HUSBAND OR WIFE Deceased.	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -	16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME Virgil Watson ADDRESS Cameron, Mo	
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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, ashenia, 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) Arteriosclerotic Sanguine		7 days.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Right foot amputation of Rt leg above knee - 5-15-56 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 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) 4501
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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?
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22. I hereby certify that I attended the deceased from **JAN 4 1956** to **5-19 1956**, that I last saw the deceased alive on **5-19 1956**, and that death occurred at **12:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE J. D. Jones (Degree or title) M.D.	23b. ADDRESS Cameron Mo	23c. DATE SIGNED 5-28-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE May 21-1956	24c. NAME OF CEMETERY OR CREMATORY Evergreen	24d. LOCATION (City, town, or county) (State) Cameron Mo.
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DATE REC'D BY LOCAL REG. 5-31-56	REGISTRAR'S SIGNATURE Winifred W. Moser	25. FUNERAL DIRECTOR'S SIGNATURE W. Moss CRUNK ADDRESS Cameron Mo
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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 *Lee M. Church*.....

Licensed Embalmer No. *252*

P. O. Address *Carmichael*

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.