

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 26 1957

57 022529  
STATE FILE NUMBER 3765

Registration District No. 318 Primary Registration District 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>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS MO.</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Firmin Desloge H.</b>				Length of stay in 1b		STREET ADDRESS <b>218 1/2 1325 So. Grand</b>	
3. NAME OF DECEASED (Type or print) <b>BRUCE Daniel GLOVER</b>				4. DATE OF DEATH Month <b>6</b> Day <b>18</b> Year <b>57</b>		5. SEX <b>M</b> 6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>Jan 10, 1935</b>		9. AGE (In years (last birthday)) <b>22</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Poplar Bluff, Missouri.</b>	
13. FATHER'S NAME <b>Alfred D. Glover</b>				14. MOTHER'S MAIDEN NAME <b>Sarah W. Cook</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No Nil</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>A. D. Glover, Zion, Missouri.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO (b) <b>PROB. PULMONARY EMBOLISM</b> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <b>POST-POLIO</b>						INTERVAL BETWEEN ONSET AND DEATH <b>20 hrs.</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour: _____ a. m. _____ p. m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		CITY, TOWN, OR LOCATION	
21. I attended the deceased from <b>JAN. 57</b> to <b>6-18-57</b> and last saw <sup>him</sup> alive on <b>6-19-57</b> Death occurred at <b>10:15 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Ronald E. Hoffmann M.D.</b>				22b. ADDRESS <b>1325 So. Grand Blvd</b>		22c. DATE SIGNED <b>6/19/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>6-18-57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Carlisle Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Carlisle, Arkansas.</b>	
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, 4700 Washington Blvd.,</b>				25. DATE RECD. BY LOCAL REG. <b>JUN 20 '57</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>	

(Licensed Embalmer's Statement on Reverse Side)

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Successor  
of Iowa

dated

SS Jan 10, 1932

Boonville, Missouri

John W. Cook

Alfred D. Groves

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 *Edwin H. Rinehart*

Licensed Embalmer No. *42*

P. O. Address *Idonia*

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.

72-81-1 IS 1000