

FILED SEP 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29480**
8007

| | | | | | | | | | |
|--|--|--|--|---|--|---|---|--|--|
| 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 Mo. b. COUNTY _____ | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN City | | c. LENGTH OF STAY (In this place) 15 yrs. | | c. CITY OR TOWN St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 3. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 26 St. Louis Chronic Hospital | | | | e. STREET ADDRESS (If rural, give location) 2139 W. Bono (5800 Arsenal St.) | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Edward | | | b. (Middle) _____ | | c. (Last) Glynn | | 4. DATE OF DEATH (Month) (Day) (Year) 8-26-57 | | |
| 5. SEX <input type="radio"/> Male | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single | | 8. DATE OF BIRTH May - 1880 | | 9. AGE (In years last birthday) 77 3 Months | |
| 10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Nil | | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and State or Foreign Country) Mo. | | | 12. CITIZEN OF WHAT COUNTRY U.S. | |
| 13a. FATHER'S NAME John S. Glynn | | | 13b. MOTHER'S MARDEN NAME Mary Slattery | | | 14. NAME OF HUSBAND OR WIFE -- | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT'S SIGNATURE OR NAME John Glynn, 1450 Mundy Dr. Florissant | | | | ADDRESS _____ | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilateral Lower Lobe Pneumonia | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2.5 days | |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | ANTECEDENT CAUSES | | | | | | 15 yrs | |
| | | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 490X | | | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS arteriosclerotic Heart Disease Conditions contributing to the death but not related to the disease or condition causing death. acute gen. arteriosclerosis | | | | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | | | 20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 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) _____ | | 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 3-13-42 , 19____, to 8-26-57 , 19____, that I last saw the deceased alive on 8-26-57 , 19____, and that death occurred at 8:10p m., from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) John W. Bechtelmann, M.D. | | | | 23b. ADDRESS 5800 Arsenal St. | | | 23c. DATE SIGNED 8/27/57 | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE Aug 28 1957 | | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 24d. LOCATION (City, town, or county) (State) Flors. Mo. - | | | |
| DATE REC'D BY LOCAL REG. AUG 27 57 | | REGISTRAR'S SIGNATURE J. Carl Smith, M.D. | | | FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly, 3860 Lincoln Blvd. | | | | |

(Licensed Embalmer's Statement on Reverse Side)

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 *W. M. Sellen*

Licensed Embalmer No. *469*
P. O. Address *3840*

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.