

FILED JAN 8 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

47122  
STATE FILE NUMBER

Registration District No. 378 Primary Registration District No. 4552 Registrar's No. 59

1. PLACE OF DEATH a. COUNTY <b>Wright</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Wright</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mountain Grove</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Mountain Grove</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>620 North Main St.</b>		Length of stay in 1b <b>18 Years</b>	d. STREET ADDRESS (If outside, give location) <b>620 North Main Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ada</b> Middle <b>Glenn</b> Last <b>Glenn</b>			4. DATE OF DEATH <b>December 14, 1957</b> Month Day Year		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 27, 1882</b>	9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>17</b> IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (City and state or country) <b>Fair Play, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Thomas E. Harris</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Elbert Glenn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Elbert Glenn Mountain Grove, 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>Myocardial infarction</b>				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>4201</b>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 COUNTY STATE	
21. I attended the deceased from <b>Dec. 12-1957</b> to <b>Dec. 14-1957</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>Dec. 14-1957</b> Death occurred at <b>12:50 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Dr. Clarence H. K.</b>			22b. ADDRESS <b>Mtn. Grove Mo.</b>		22c. DATE SIGNED <b>12-16-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/16/1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Houston Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Houston, Missouri</b>
24. FUNERAL DIRECTOR <b>Barber Funeral Home</b>		ADDRESS <b>Mtn. Grove, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>12-28-57</b>	26. REGISTRAR'S SIGNATURE <b>A. B. Ames</b>	

Securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
 All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

Date Filed 1-6-57  
 County File Number 15821  
 HEALTH DEPT.  
 Dec. 31, 1957

**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 *George Stapp* .....  
 Licensed Embalmer No. 3161

P. O. Address *Mrs. Stapp* .....

**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.