

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027807  
STATE FILE NUMBER

FILED JUL 24 1958

Registration District No.

317

Primary Registration District No.

500

Registrar's No.

1872

1-57

|  |  |  |  |   |   |  |   |  |
|--|--|--|--|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY                                       |   |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>Manchester Mo.</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  | c. CITY OR TOWN <b>St. Louis</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>     |   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Manchester Nursing Home MONS. 2/29</b>   |  |  | Length of stay in lb   |   | d. STREET ADDRESS (If outside, give location)<br><b>5112 Waterman</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |  |
| 3. NAME OF DECEASED (Type or print)<br><b>PAUL Glaser</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>14</b> Year <b>58</b>   |   |  |   |  |
| 5. SEX <b>male</b>   |  | 6. COLOR OR RACE <b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>9/17, 1917</b>  |   |  |
| 9. AGE (In years last birthday)<br><b>40</b>   |  | 10. FUNDER 1 YEAR<br>Months  |  | 11. IF UNDER 24 HRS.<br>Hours   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>   |   | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis Mo.</b>    |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13a. FATHER'S NAME<br><b>Edwin Glaser</b>  |  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Aldred Rubel</b>   |   |   | 14. NAME OF HUSBAND OR WIFE<br><b>NONE</b>   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  |  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |   | 17. INFORMANT<br><b>Edwin V. Glaser 5112 Waterman</b>                 |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-VASCULAR RENAL DISEASE</b>   |  |  |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b>  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |  | DUE TO (b) <b>DEVELOPMENTAL ANOMALY FROM BIRTH.</b>                                  |  | DUE TO (c) <b>-</b>   |   | 759.3  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>NONE</b>   |  |  |  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 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.)<br><b>-</b> |   |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour<br>a.m.<br>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.)<br><b>-</b>   |  |  | 20f. CITY, TOWN, OR LOCATION   |   | COUNTY  |  | STATE   |  |
| 21. I attended the deceased from <b>OCT. 1, 1958</b> to <b>JULY 14, 1958</b> and last saw him alive on <b>JULY 14, 1958</b><br>Death occurred at <b>1:45 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |  |  |  |   |   |  |   |  |
| 22a. SIGNATURE<br><b>B.R. Loving (Deegee or title)</b>   |  |  |  | 22b. ADDRESS<br><b>BALLWIN, Mo.</b>   |   |  | 22c. DATE SIGNED<br><b>7-15-58</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |  | 23b. DATE<br><b>7/16/58</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Sinai</b>   |   |   | 23d. LOCATION (City, town, or county) (State)<br><b>8400 Gravois Ave, St. Louis, Mo.</b> |   |  |
| 24. FUNERAL DIRECTOR<br><b>Mayer</b>   |  |  | ADDRESS<br><b>4356 Lindell Blvd</b>  |   | 25. DATE RECD. BY LOCAL REG.<br><b>7-15-58</b>                        | 26. REGISTRAR'S SIGNATURE<br><b>Hubert P. Ormbe M.D.</b>                                 |   |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Secretary, Cemetery, Registrar, or other authorized official must be present. All diseases in Part I must be causally related.

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 *Stanley E. Dixon* .....

Licensed Embalmer No. *4193* .....

P. O. Address *St. L.* .....

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.