

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007140
STATE FILE NUMBER
2 1194

FILED FEB 17 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4646 Cottage		Length of stay in lb 55 yrs.	d. STREET ADDRESS 4646 Cottage
3. NAME OF DECEASED (Type or print) First Middle Last ALBERT GLASS			4. DATE OF DEATH Month Day Year January 31, 1959
5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Hammer		10b. KIND OF BUSINESS OR INDUSTRY Scullin Steel	11. BIRTHPLACE (City and state or country) Paducah, Kentucky
13a. FATHER'S NAME Albert Glass		13b. MOTHER'S MAIDEN NAME Nancy ?	14. NAME OF HUSBAND OR WIFE Caddie L. Glass
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 492-09-31114	17. INFORMANT Address Caddie Glass 4646 Cottage Avenue
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>nephritis, chr</u>			INTERVAL BETWEEN ONSET AND DEATH 2 mos
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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
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 COUNTY STATE
21. I attended the deceased from <u>Nov 58</u> to <u>Jan 31-59</u> and last saw <u>her</u> alive on <u>Jan 20-59</u> Death occurred at <u>547A 1-31-59</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Charles J. Gates</u> (Degree or title)		22b. ADDRESS <u>450 1st Street</u>	22c. DATE SIGNED <u>2-3-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2/6/59	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR Charles J. Gates		ADDRESS 4107 Finney	25. DATE RECD. BY LOCAL REG. FEB 3 '59
26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>			

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Gunston Swan*

Licensed Embalmer No. 4580

P. O. Address 4107 Finney Ave

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.