

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032164

FILED VS SEP 21 1959

Registration District No. 141 Primary Registration District No. 555 Registrar's No. 121

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Howell</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		Length of stay in lb <u>hours</u>	c. CITY OR TOWN <u>West Plains</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rural</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Pottersville Rte</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Glenn</u> Last <u>Glenn</u>			4. DATE OF DEATH Month <u>9</u> Day <u>4</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-9-1882</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>26</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Store</u>	11. BIRTHPLACE (City and state or country) <u>Berch Grove Ky</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME <u>Boyd Glenn</u>		13b. MOTHER'S MAIDEN NAME <u>Josephine Coads</u>		14. NAME OF HUSBAND OR WIFE <u></u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Yes</u>	17. INFORMANT <u>Harold Glenn, West Plains Mo</u>		
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>Myocardial infarction</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 h</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary thrombosis</u>					<u>2 h</u>
DUE TO (c) <u>Generalized arteriosclerosis</u>					<u>15 y</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)		
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>					
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>3/22/58</u> to <u>9/4/59</u> and last saw him ^{xxx} live on <u>9/4/59</u>			Death occurred at <u>11:00P</u> am on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>Dr. Callahan</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>West Plains, Missouri</u>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>9-6-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Houston</u>	23d. LOCATION (City, town, or county) (State) <u>Houston Missouri</u>		
24. FUNERAL DIRECTOR <u>Robertson's, West Plains Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-17-59</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		

DOCUMENT

MEDICAL CERTIFICATION

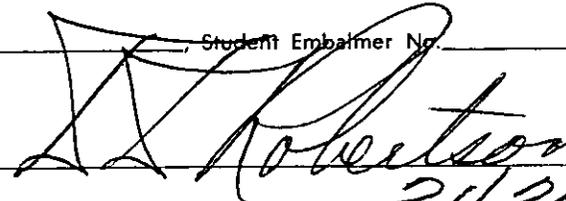
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 343

P. O. Address West

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.