

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 8 1960

8587-60-032232
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

RECEIVED

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, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>4 yr. 8 mo. 18 days</u>	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chronic Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1401 Newhouse</u>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle _____ Last <u>Glasker</u>			4. DATE OF DEATH Month <u>9</u> Day <u>1</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-4-1874</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Wholesale Buyer of Millinery</u>			11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Glasker</u>		13b. MOTHER'S MAIDEN NAME <u>Louisa Kahmann</u>		14. NAME OF HUSBAND OR WIFE -----	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. O.D. Meyer 6029 S. Kingshighway Blvd.</u>	Address
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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>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 yrs.</u>
DUE TO (b) _____		<u>4200 F</u>
DUE TO (c) <u>Generalized Arteriosclerosis</u>		<u>4 1/2 yrs.</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>Left Intertrochanteric Fract. Femur - 3 mo.</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input checked="" 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.) <u>fx. got up from chair in hall + fell to the floor on the left hip.</u>
20c. TIME OF INJURY <u>3:45 p.m.</u>	Month, Day, Year <u>5/29/60</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>St. Louis Chronic Hosp.</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>
21. I attended the deceased from <u>12-13-55</u> to <u>9-1-60</u> and last saw her alive on <u>9-1-60</u>		Death occurred at <u>5:25 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>John W. Beckham, M.D.</u>	(Degree or title)	22b. ADDRESS <u>5800 Arsenal</u>	22c. DATE SIGNED <u>9/1/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sep. 2, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Friedens Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
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24. FUNERAL DIRECTOR <u>Kriegshauser 4228 S. Kingshighway Blvd.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>SEP 1 1960</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Paul J. Smith
Deputy Coroner*

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 *R. W. Stovesand*

Licensed Embalmer No. 4007

P. O. Address _____

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.