

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4110 -61-015166
 STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>St. Louis</u>		a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis 97, Missouri</u>	
Length of stay in lb		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Missouri Baptist Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>10656 Spring Garden Dr.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH
<u>Bonnie Michele Glazer</u>			Month <u>April</u> Day <u>15</u> Year <u>1961</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>4-16-1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>10</u>
		<u>Kirkville, Missouri</u>	IF UNDER 1 YEAR Months Days
			IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY	
<u>Kirkville, Missouri</u>		<u>USA</u>	
13a. FATHER'S NAME <u>Martin Glazer</u>		13b. MOTHER'S MAIDEN NAME <u>Rose Ann McAndrew</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)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>10656 Spring Garden St. Louis, Mo.</u> <u>Martin Glazer</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>			<u>1 day</u>
DUE TO (b) <u>Cerebral Palsy, spastic type</u>			<u>11 yrs.</u>
DUE TO (c) <u>351x</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? 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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
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>4-14-61</u> to <u>4-14-61</u> and last saw her/him alive on <u>4-14-61</u> Death occurred at <u>9 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert L. Kohn M.D.</u>		22b. ADDRESS <u>150 N. Meramec, Clayton, Mo.</u>	22c. DATE SIGNED <u>4-27-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-15-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kahoka City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kahoka, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>D. L. Shaffer, Kahoka, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 1 1961</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

DATE AMENDED
 ITEM NO.
 BY AFFIDAVIT OF
 DOCUMENT
 INSTEAD OF
 SHOULD READ

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 _____

Licensed Embalmer No. _____

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.