

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-008150

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 52

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0428

2 0428v

3

4 1

5 2

6

7 0

8 2

9443X

10

11

12 90-0

13 4-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>		Length of stay in Td <u>Life</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>708 S. Sixth St.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location); <u>708 S. Sixth St.</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Anna</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>14,</u> Year <u>1963</u>	
First <u>Anna</u> Middle <u>Glosier</u> Last <u>Glosier</u>			
5. SEX <u>Female</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>Oct. 23, 1873</u>
9. AGE (last birthday) <u>89</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>21</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Luke Pallardy</u>		13b. MOTHER'S MAIDEN NAME <u>Ellen Spinks</u>	
14. NAME OF HUSBAND OR WIFE <u>Henry I. Glosier</u>			
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>[REDACTED]</u>	
17. INFORMANT <u>Mrs. Lillian Siedhoff, St. Charles, Mo.</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u></u>			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 checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. HOMICIDE <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u></u>			
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <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.) <u></u>	
20f. CITY, TOWN, OR LOCATION <u></u>		COUNTY <u></u> STATE <u></u>	
21. I attended the deceased from <u>Jan 26 - 1956 to Feb 14 - 63</u> and last saw her alive on <u>Feb 11 - 63</u> Death occurred at <u>7:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Vincent B. Selinger MD</u>		22b. ADDRESS <u>St. Charles, Mo.</u>	
22c. DATE SIGNED <u>2-15-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 18, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Charles, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>H.C. Dallmeyer & Sons, St. Charles, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Feb 17, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>

USE BLACK INK OR TYPEWRITER RIBBON

8243
62220

1
6
0
0

0-02

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 Charles J. Macke

Licensed Embalmer No. 4530

P. O. Address St. Charles, Mo

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.