PLACE OF DEATH

County Johnson

Township Jackson

or

Village

or

City (NO. St.: Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 435 File No. 19741

Primary Registration District No. 5591 Registered No. 5

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Thomas Dudley Glover

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE White

~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ ~~(Write the word)~~ widowed

DATE OF BIRTH Mar 14 (Month) (Day) 1837 (Year)

AGE 77 yrs. X mos. 28 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Ky

PARENTS

NAME OF FATHER Chas Glover

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky

MAIDEN NAME OF MOTHER Miss Dorsey Wm

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. R. Glover

(ADDRESS) Pleasant Hill Mo

Filed 6-23, 1914. W. B. Turnbow By J. C. Angelle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April (Month) 12 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from 3-26, 1914, to 4-12, 1914, that I last saw him alive on 4-10, 1914, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

106 [illegible]

111 [illegible]

(Duration) ___ yrs. ___ mos. 17 ds.

Contributory (SECONDARY) Chronic Bronchitis

(Duration) 10 yrs. ___ mos. ___ ds.

(Signed) Wm Beckman M. D.

4-12, 1914 (Address) Strasburg Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Bluff Springs

DATE OF BURIAL 4-13, 1914

UNDERTAKER Parker & Hon

ADDRESS ~~Parker & Hon~~ Pleasant Hill Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... , 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... , 191.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(Secondary)
.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS