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

PLACE OF DEATH

County Linn

Township Locust Creek

or

Village ~~Infirmary~~

or

City _____ (NO. _____ St.: _____ Ward)

Registration District No. 501 File No. 15146

Primary Registration District No. 5666 Registered No. 12

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

FULL NAME John Glenn

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (*Write the word*): Single

DATE OF BIRTH: ~~1832~~ April 2, 1832 (Month) (Day) (Year)

AGE: 83 yrs. 11 mos. 29 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work: Dependent Infirmary

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

BIRTHPLACE (City or town, State or foreign country): Kentucky

PARENTS

NAME OF FATHER: Absolom Glenn

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

MAIDEN NAME OF MOTHER: Pepper

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. O. Home

(ADDRESS) Linneus Mo.

Filed 4/2, 1916. F. D. Bates REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April (Month) 1 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased ~~from~~ April 1, 1916, to _____, 191__, that I last saw him alive on April 1, 1916, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

64

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

Contributory (SECONDARY) _____

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

(Signed) L. O. Home M. D.

April 2, 1916 (Address) Linneus 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: A. S. O. Kirkwood Mo

DATE OF BURIAL: X, 191X

UNDERTAKER: M. G. Reeves

ADDRESS: Brookfield Mo

specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTI
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ *or*
Village _____ *or*
City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If dea
hospital
give its
of street

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 _____
(Month) (D

I HEREBY CERTIFY, that I attended de
_____, 191____, to _____
that I last saw h _____ alive on _____
and that death occurred, on the date stated above,
The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mo

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mo

(Signed) _____

_____, 191____ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TR
RECENT RESIDENTS)

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

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BU
UNDERTAKER	ADDRESS