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

PLACE OF DEATH

County Phelps

Township ~~St James~~ or Village or City St James (NO. ____ St.; ____ Ward)

Registration District No. 678 File No. 132520

Primary Registration District No. 4404 Registered No. ____

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

FULL NAME Curtis Glenn

PERSONAL AND STATISTICAL PARTICULARS

SEX male

COLOR OR RACE White

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

DATE OF BIRTH 1839 Sep 27 (Month) (Day) (Year)

AGE 77 yrs. 6 mos. 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) ~~[illegible]~~

BIRTHPLACE (City or town, State or foreign country) St. Louis Co. Mo.

PARENTS
NAME OF FATHER Joseph Glenn
BIRTHPLACE OF FATHER (City or town, State or foreign country) dont knows
MAIDEN NAME OF MOTHER dont know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) dont knows

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ellen Brinckhat

(ADDRESS) St James Mo

Filed Jan 28, 1917 Mrs. Florence Matlock REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 27, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 21, 1917, to January 27, 1917, that I last saw him alive on Jan 27, 1917, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

131
11A LaGrippe Pneumonia
107A

(Duration) ___ yrs. ___ mos. 7 ds.

Contributory (SECONDARY) Chronic Interstitial Nephritis

(Duration) 2 yrs. ___ mos. ___ ds.

(Signed) W H Brewer M. D.

1-28-1917 (Address) St James 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 Masonic Cem

DATE OF BURIAL 1-28, 1917

UNDERTAKER W E Lickleder

ADDRESS St James Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. *The* material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise 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 as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc. of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia*," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a 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 which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

1 PLACE OF DEATH

County: Phelps

Township ..... or Village ..... or City: St. James (NO. ..... St.; ..... Ward)

Registration District No. 678 File No. .....

Primary Registration District No. 4404 Registered No. 13

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

2 FULL NAME Curtis Glenn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Divorced

6 DATE OF BIRTH: ..... (Month) ..... (Day) ..... 1 (Year)

7 AGE: ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country) .....

PARENTS

10 NAME OF FATHER .....

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

12 MAIDEN NAME OF MOTHER .....

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15 Filed 3-24, 191 7 Mrs. Florence Mathews Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan. 27, 191 7 (Month) (Day) (Year)

17 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:

La Grippe

Pneumonia

Broncho-Pneumonia

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

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

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

(Signed) W. H. Greene M. D.

1-28, 191 7 (Address) St. James, Mo.

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

18 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 .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ..... 191.....

20 UNDERTAKER

ADDRESS

SUPPLEMENTARY

Original file, date ....., 19.....

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

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