

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH
County Linn
Township Libo
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 349 File No. 28381
Primary Registration District No. 5487 Registered No. 10

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

FULL NAME Vera Lee Glazbrook

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Infant
(Write the word)

DATE OF BIRTH Apr 6, 1917
(Month) (Day) (Year)

AGE 4 yrs. 4 mos. 4 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

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

PARENTS
NAME OF FATHER Graves Glazbrook
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
MAIDEN NAME OF MOTHER Maudie Venable
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lee Venable

(ADDRESS) Linton

Filed Aug 7, 1917 Q. A. Gray REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 6, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 6, 1917, to Aug 6, 1917, that I last saw him alive on Aug 3, 1917, and that death occurred, on the date stated above, at 11.0 m.

The CAUSE OF DEATH* was as follows:

Splina Bifida
15 11 12
79A
150

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

Contributory meningitis
(SECONDARY)

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

(Signed) W. A. Paine M. D.

8/7 1917 (Address) Linton

*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 Linton

DATE OF BURIAL May 8, 1917

UNDERTAKER W. A. Paine

ADDRESS Linton

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____ (NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered 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 (If rise the word)
DATE OF BIRTH _____ (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) _____

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) _____ (Day) _____ (Year) 191 _____

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:

Contributory

(SECONDARY)

(Signed) _____

191 _____ (Address) _____

M. D. _____

*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. State _____ 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 _____

UNDERTAKER _____

ADDRESS _____