

SEP 26 1927

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

Do not use this space.

23693

1. PLACE OF DEATH

County... Buchanan Registration District No. 85
Township..... Primary Registration District No. 10
City... St. Joseph, (No. St. Joseph, s Hospital St. Ward)

File No.
Registered No. 859
St. Ward)

2. FULL NAME Mildred Cecil Gleason

(a) Residence. No. 1334 Buchanan Avenue St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William H. Gleason

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July, 20, 1888

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>39</u>	<u>I</u>	<u>7</u>	

8. OCCUPATION OF DECEASED

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

128
127
124

9. BIRTHPLACE (CITY OR TOWN) Coin, (STATE OR COUNTRY) Iowa.

10. NAME OF FATHER James Wilson.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown (STATE OR COUNTRY) Indiana.

12. MAIDEN NAME OF MOTHER Laura Miller.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) New Market, (STATE OR COUNTRY) Iowa

14. INFORMANT William H. Gleason. (Address) 1334 Buchanan Avenue

15. FILED Aug 29 1927 19..... John G. W. REGISTRAR

5 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August, 27, 1927.

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1927, to August 27 1927 that I last saw h. er alive on Aug. 27, 1927, and that death occurred, on the date stated above, at 3/50 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Pancreatitis
Chronic Cholecystitis
Common duct Obstruction
Chronic Carcinoma of Pan (duration) yrs. mos. da. 3
CONTRIBUTORY (SECONDARY) Internal hemorrhages from Choleliths (duration) yrs. mos. da. 3

18. WHERE WAS DISEASE CONTRACTED

Id. no form
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? Yes (DATE OF Aug. 23 - 92)
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms
Gross Pathology Microscopy M. D.
Exam. by Dr. J. G. W.
Aug. 29, 1927 (Address) St. Joseph, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mount Auburn Cemetery DATE OF BURIAL Aug. 30, 1927.

20. UNDERTAKER H. O. Sidenfader ADDRESS 1802 Union Str.

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.

