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

791
1003

28834
8382

1. PLACE OF DEATH

County ..... Registration District No. 791
Township ..... Primary Registration District No. 1003
City St. Louis Mo. (No. Home of the Aged St. ..... Ward)

File No. 28834
Registered No. 8382

2. FULL NAME John Glew

(a) Residence. (Usual place of abode) (No. 2209 Hebert St., 20 Ward. ..... (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)
male	White	Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widower of Margaret Mac Farland

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 13. 1844.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83.	4	6.	

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

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Scotland.

PARENTS
10. NAME OF FATHER Wm. Glew.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Scotland
12. MAIDEN NAME OF MOTHER Catherine Griffin
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) .....

14. INFORMANT Sr. Ignace de Loyola
(Address) 2209 Hebert

15. FILED ..... 21 1927 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 19, 2.30 P.M. 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 ..... 19 22, to Sept. 19, 1927 that I last saw h. alive on Sept. 19, 1922, and that death occurred, on the date stated above, at 3.30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
936
1-3-928
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Examination
(Signed) Anthony A. Piekarski, M. D
9/20. 1927 (Address) 1502 Cass Ave.

*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 Calvary — DATE OF BURIAL 9-21 1927

20. UNDERTAKER Arthur J. Donnelly — ADDRESS 2039 Wash St.

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.

THIS IS A PERMANENT RECORD

Dr Prekanke

1502 C. a.