

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

Do not use this space.

11902

1. PLACE OF DEATH

County..... Leath
Township..... Granua
City..... (No.....) St..... Ward.....

Registration District No..... 820
Primary Registration District No..... 4496

File No.....
Registered No.....

2. FULL NAME

William Price Glascock

(a) Residence No..... St..... Ward.....
(Usual place of abode)

(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

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

widowed

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

Martha Glascock

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

1/18/44

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

84

2

3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Farmery

(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)

Ky.

10. NAME OF FATHER

Don't know

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

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

Don't know

14.

INFORMANT (Address)

Tom Glascock

15.

FILED

90, 1928
W. H. H. Registrar

2. MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR)

3/21 1928

17.

I HEREBY CERTIFY, That I attended deceased from 3/12, 1928, to 3/20, 1928 that I last saw him alive on 3/20, 1928, and that death occurred, on the date stated above, at 330 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Endocarditi
92 A
160 (duration) yrs. 6 mos. — ds.
CONTRIBUTORY (SECONDARY) Senility
(duration) 1 yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH?

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) W. H. H., M. D.
35 (Address) Oran 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

DATE OF BURIAL

Friend Cemetery

3/22 1928

20. UNDERTAKER

ADDRESS

W. H. H. Registrar

Oran Mo

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.

