

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

Do not use this space.

5876

**1. PLACE OF DEATH**

County Clinton

Registration District No. 707

File No. 17

Township Plattsburg

Primary Registration District No. L176

Registered No. 6

City Plattsburg (No. ....) St. .... Ward

**2. FULL NAME John F. Glennon**

(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 25 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

M

**4. COLOR OR RACE**

W.

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

married

**5A. IF MARRIED, WIDOWED, OR DIVORCED**

HUSBAND OF (OR) WIFE OF Maggie C. Glennon

**6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-4-1853**

**7. AGE**

76

**YEARS**

**MONTHS**

1

**DAYS**

10

If LESS than 1 day, .... hrs. or .... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Auxiliary of the Peace for

(b) General nature of industry, business, or establishment in which employed (or employer) Concord township

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN) Long Island**

(STATE OR COUNTRY) New York

**10. NAME OF FATHER James Glennon**

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

**12. MAIDEN NAME OF MOTHER Margaret Fitzgerald**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**  
(STATE OR COUNTRY) New York State

**14. INFORMANT Mary M. Sage C. Glennon**

(Address) Plattsburg Mo.

**15. FILED Feb 18 1929**

J. E. Tasham REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb-14 1929**

17. I HEREBY CERTIFY That I attended deceased from Feb-6 1929 to Feb-14 1929

that I last saw him alive on Feb-15 1929, and that death occurred, on the date stated above, at 2 a. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Sub acute hepatitis

**CONTRIBUTORY (SECONDARY)**

**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? urinalysis

(Signed) Dr. Stecker, M. D.

2-15 1929 (Address) Plattsburg 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**

Plattsburg Mo

**DATE OF BURIAL**

2-16 1929

**20. UNDERTAKER**

Paul N. Nelson

**ADDRESS**

Plattsburg Mo

N. B.—Every item of information CAUSE OF DEATH in plain terms, so that it may be properly classified.

1929  
25  
4  
2

206

2

15

2

176

CAUSE OF DEATH IN CASES OF SUICIDE. It may be necessary also to back statements.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Clinton  
Township Plattsburg  
City Plattsburg (No. \_\_\_\_\_)

Registration District No. 207  
Primary Registration District No. 4121

File No. 17  
Registered No. 6  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

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

10. NAME OF FATHER \_\_\_\_\_

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

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

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

14.

INFORMANT \_\_\_\_\_  
(Address) \_\_\_\_\_

15.

FILED 3/8/29 [Signature]  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 14 1929

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_ that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Subacute Nephritis  
Do not know cause  
of nephritis  
(duration) yrs. mos. ds. 7

CONTRIBUTORY (SECONDARY) \_\_\_\_\_  
(duration) yrs. mos. ds. 128

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

, 19 (Address) \_\_\_\_\_

\*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 \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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

Every item of L.S. is then to be carefully supplied. AGE should be stated EXACTLY. OCCUPATION is very important. DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**SUPPLEMENTARY**

1123

S-5876