

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

Do not use this space.

20816

1. PLACE OF DEATH

County Butler
Township Poplar Bluff
City Poplar Bluff

Registration District No. 89
Primary Registration District No. 3007

File No. _____
Registered No. 107
St. _____ Ward) _____

2. FULL NAME

Margie M. Glasson
(a) Residence. No. 308 N. "B" 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 F 4. COLOR OR RACE W- 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 1926 Est.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1924 Est.
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min. 3 Est.

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) Fish
(STATE OR COUNTRY) mo.

10. NAME OF FATHER Frank M. Glasson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Metropolis
(STATE OR COUNTRY) Ill.
12. MAIDEN NAME OF MOTHER Helen Bushum
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Cape Girardeau
(STATE OR COUNTRY) mo.

14. INFORMANT Frank M. Glasson
(Address) Poplar Bluff

15. FILED 6/6 1927 Dr. J. C. Camp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-5 1929
17. I HEREBY CERTIFY, That I attended deceased from 6-2, 1929, to 6-5, 1929 that I last saw her alive on 6-5, 1929, and that death occurred, on the date stated above, at 11 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Meningeal meningitis
6-4-29 (duration) _____ yrs. _____ mos. 3 ds.
18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

CONTRIBUTORY (SECONDARY) Acidosis
(duration) _____ yrs. _____ mos. _____ ds.

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Culture of Syn
(Signed) W. H. K. ... M. D.

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.
6-6, 1929 (Address) Poplar Bluff

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Woodlawn DATE OF BURIAL 6-7 1929

20. UNDERTAKER Frank's Undertaking Co., Poplar Bluff

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. CASE NO. 1-1-1

11-11-68

11-11-68

11-11-68

**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 Butler Registration District No. 89 File No. _____
 Township _____ Primary Registration District No. 3007 Registered No. 107
 City Poplar Bluff (No. _____) 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 <u>F</u>		4. COLOR OR RACE <u>W</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>S</u>	
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)					
PARENTS	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)				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-5-1929

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:
uremic poisoning
of non-diabetic
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Acidosis
 (duration) _____ yrs. _____ mos. _____ ds.

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.

14. INFORMANT (Address) _____

15. FILED July 7 1929 Dr J J Clay REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19____
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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

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