

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

Do not use this space.

28264

1. PLACE OF DEATH

County Lawrence Registration District No. 470
 Township West Vernon Primary Registration District No. 5633
 City (No.) St. Ward (No.)

2. FULL NAME Mrs. J. H. Glines

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

Length of residence in city or town where death occurred 0 yrs. 0 mos. 20 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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 J. H. Glines

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 20, 1886

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
43 8 11

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

9. BIRTHPLACE (CITY OR TOWN) St. Clair Co. Mo.
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER J. A. Chambers

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

12. MAIDEN NAME OF MOTHER Sarah Hunter

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

14. INFORMANT Mrs. St. Clair Needs
 (Address) West Vernon Mo.

Sept 10 1929 W. J. Fulton
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 1 1929

17. I HEREBY CERTIFY, That I attended deceased from July 12, 1929, to Aug 1, 1929
 that I last saw him alive on Aug 1, 1929, and that death occurred, on the date stated above, at 12:40 p.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Pulmonary Tuberculosis
Far advanced
93R (duration) yrs. 7 mos. ds.

CONTRIBUTORY myocarditis
 (SECONDARY) (duration) yrs. mos. ds. 10 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, Lawrence Mo.

DID AN OPERATION PRECEDE DEATH? no DATE OF —

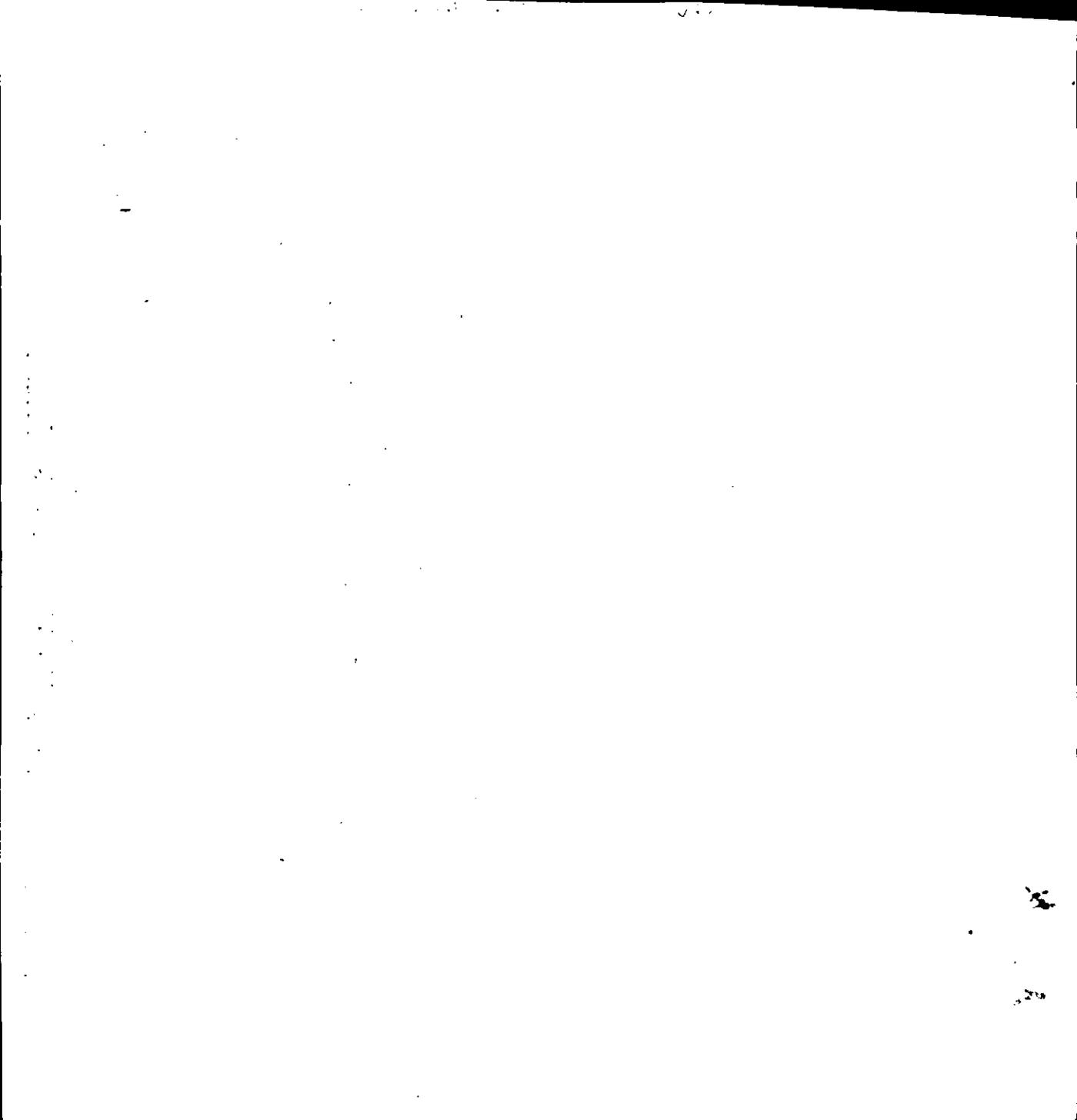
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? X-ray laboratory
 (Signed) S. E. Adams, M. D.
 , 19 (Address) MO. S.S. West Vernon, 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 Collinsville DATE OF BURIAL Aug 2 1929

20. UNDERTAKER Phillips & Fox ADDRESS West Vernon Mo.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Lawrence Registration District No. 470
 Township Mt Vernon Primary Registration District No. 33 File No.
 City..... (No.) St. Ward) Registered No. 38

2. FULL NAME Mrs J. H. Glimm

(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 7 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) July 20, 1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hr. ormin.
42 8 11

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. 9/10/29 W. F. FULTON REGISTRAR
 FILED 19 29

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 1 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:

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

RECEIVE A COPY OF THIS CERTIFICATE AS PRESCRIBED BY LAW

5-28264