

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.

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

445  
 Do not use this space.

REC'D FEB 10 1939

1. PLACE OF DEATH

(a) County ..... Registration District No. **791**  
 (b) Township ..... Primary Registration District No. **1003**  
 or **ST. LOUIS Mo.** (d) Street No. **5600 ARSENAL ST.**  
 City **Mo.** **WIFE** (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **CATHERINE GLASBY**

(a) Residence, No. **220 South L. E. KING MALL** St. **22** (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **FEMALE** 4. COLOR OR RACE **COLORED** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **SINGLE**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug. 26, 1936**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**2 4 16**

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, MISSOURI**

FATHER

13. NAME **JILES GLASBY**  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **MURPHYSBORO, ILLINOIS**

MOTHER

15. MAIDEN NAME **MALISSA JOHNSON**  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **ARKANSAS**

17. INFORMANT **B. BUTTENTUTH** (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE **E. ST. LOUIS, ILL** DATE **1/15 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **W. M. GREEN 3517 BUCKLED AVE**

20. FILED **JAN 13 1939 J. F. BRIDICK** Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **JAN: 11, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **JAN. 1, 1939**, to **JAN. 11, 1939**.  
 I last saw **h. R.** alive on **JAN. 11, 1939**. Death is said to have occurred on the date stated above, at **5:20 p.m.**  
 The principal cause of death and related causes of importance were as follows:  
**Pertussis**  
 Date of onset

Other contributory causes of importance:  
**Bronchopneumonia**

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide..... Date of injury..... 19.....  
 Where did injury occur?..... City or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **1**  
 If so, specify.....  
 (Signed) **Earl C. Ogilvie** M. D.  
 (Address).....

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by *me*.

....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*M. Green*

Licensed Embalmer No. *1173*

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**