

JUL 18 1939

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

22897  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Little Prairie Registration District No. 861  
 (b) Township Democrat Primary Registration District No. 2862  
 (c) City \_\_\_\_\_ (d) Street \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred \_\_\_\_\_ yrs. mos. da. (f) How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. mos. da.

2. PRINT FULL NAME Glasper  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ (If nonresident, give city or town and State) \_\_\_\_\_

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE B 5. SINGLE/MARRIED, WIDOWED, OR DIVORCED Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 10/39

7. AGE YEARS 0 MONTHS 3 DAYS 10 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
 9. Industry or business in which work was done, as saw mill, bank, etc. None  
 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) Democrat Mo

FATHER  
 13. NAME Unknown  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER  
 15. MAIDEN NAME Alberta Glasper  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Democrat Mo

17. INFORMANT (ADDRESS) Ernest Glasper  
 18. BURIAL, CREMATION, OR REMOVAL PLACE County Farm DATE June 20 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Friedrichs  
 20. FILED June 20 1939 Ada Martin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 20 1939

22. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
 I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m. The principal cause of death and related causes of importance were as follows: unknown

No attending Physician

Other contributory causes of importance: 2 DD b

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? \_\_\_\_\_ (Specify 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? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) Fred. C. Oyster M.D.  
 (Address) Caruthville

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

RECEIVED

District Health Officer No. 3,

District File Number 739-406

Date Filed 7/8/39

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**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.....

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

Signed.....

Licensed Embalmer No.....

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.**