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.

SEP 8 1939

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

Do not use this space.

File No. 28883

Registered No. 108

1. PLACE OF DEATH

County Clay

Township Fishing River

City Excelsior Springs (No. Veterans Administration Facility St. 3d Ward)

Registration District No. 198

Primary Registration District No. 3011

416

2. FULL NAME GLOVER, Daniel T.

(a) Residence, No. 206 North Harrison St., Ward. Enid, Oklahoma
(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. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

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~~ Violet Glover

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-11-92

7. AGE: Years 46 | Months 9 | Days 4 | If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, 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) Bogard, Mo

FATHER

13. NAME Benjamin Glover

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER

15. MAIDEN NAME Mary Mathieson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Hospital Records

18. BURIAL, CREMATION, OR REMOVAL

PLACE Bogard, Mo DATE 8-15-39, 19

19. UNDERTAKER (ADDRESS) Dickerson Funeral Home Bogard, Mo

20. FILED Aug 15, 1939 Mrs Rua McCracken Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 15, 1939, 19

22. I HEREBY CERTIFY, That I attended deceased from 8-9-39, 19, to 8-15-39, 19

I last saw him alive on 8-15-39, 19. Death is said to have occurred on the date stated above, at 2:25 m. a. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute fibrinous peritonitis; intestinal obstruction	
Other contributory causes of importance: Acute appendicitis	

Name of operation Appendectomy Date of 8-9-39

What test confirmed diagnosis? -- Was there an autopsy? Yes

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) John E. Kelly, M. D.

(Signed) JOHN E. KELLY, MD, Manager

(Address) Veterans Administration Facility Excelsior Springs, Missouri

RECEIVED

District Health Officer No. 8

District File Number

Date Filed 9/6/39