DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40212

Registration District No. 538 Primary Registration District No. 5726 Registrar's No. 82

1. PLACE OF DEATH:
(a) County Madison
(b) City or town Rural Twelve mile
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) Life spent here
In this community 112

2. USUAL RESIDENCE OF DECEASED: 1
(a) State Missouri (b) County Madison
(c) City or town Rural - Coldwater
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME John Levy Glaves
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Emma Wilmore Glaves
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 17 (Day) 1871 (Year)

8. AGE: Years 68 Months 8 Days 19 If less than one day hr. min.

9. Birthplace Madison Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Ruben Glaves
13. Birthplace Tennessee (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Cynthia Stevens
15. Birthplace Missouri (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Pearl Lickman
(b) Address Coldwater Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8 '39 (Month) (Day) (Year)
(c) Place: burial or cremation Coldwater, Mo
18. (a) Signature of funeral director Ed H. Webb
(b) Address Fredericktown, Mo.
19. (a) Nov 6 1939 (Date received local registrar) (b) S. C. Slaughter By C. D. Schwanke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 6 year 1939 hour 9 minute 40 A M.
21. I hereby certify that I attended the deceased from Oct 30, 1939, to Nov 6, 1939; that I last saw him alive on Nov 5th, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	
Due to Sequela of Cerebral Haemorrhage which occurred Oct 30th	
Due to resulting Hemiplegia	
Other conditions Hypertension (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature S C Slaughter (M. D. ~~or other~~) 1
Address Fredericktown Mo. Date signed 11/7/39

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 Myron A. La Rue, Registered Apprentice No. ..... working under my personal supervision.

Signed Myron A. La Rue

Licensed Embalmer No. 4025

P. O. Address Fredericktown

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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

40212
Do not use this space.

1. PLACE OF DEATH
(a) County: Madison — Registration District No.: 538
(b) Township: Twelve Mile — Primary Registration District No.: 3726 — Registered No.:
(c) City: — (d) Street No.: — St.
(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: John Levy Glaves
(a) Residence, No.: — St.
(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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): Wid

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

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

7. AGE: Years 68 — Months 8 — Days 19 — If LESS than 1 day, ...hrs. or ....min.

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)

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

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE — DATE ....19..

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Jan 16 1940 S. C. Slaughter
By C. A. Dee Deputy

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 6 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:

	Date of onset
Pneumonia Lobar	
108	

Other contributory causes of importance:
Sequela of Cerebral Hemorrhage Oct 30 resulting Hemiplegia

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) S. C. Slaughter, M. D.
(Address) Fredericktown Mo

SUPPLEMENTARY

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write its 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 COMPLETED AS PRESCRIBED BY LAW.