DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9564

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 998

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C.Genera Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 months (Specify whether

In this community 18 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 608 West 39th St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME: James Glore

3. (b) If veteran, name war: None

3. (c) Social Security No.: no

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife: --

6. (c) Age of husband or wife if alive: -- years

7. Birth date of deceased: Aug. 14, 1879 (Month) (Day) (Year)

8. AGE: Years 60 | Months 6 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace: ..... (City, town, or county) Ill (State or foreign country)

10. Usual occupation: Saborer

11. Industry or business: --

FATHER
12. Name: Robt. Glore
13. Birthplace: ..... (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name: Eliza Estes
15. Birthplace: ..... (City, town, or county) Unknown (State or foreign country)

16. (a) Informant's own signature: Mrs. John Glore

(b) Address: 608 W 39th St. K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 6-40 (Month) (Day) (Year)

(c) Place: burial or cremation: Mt Washington

18. (a) Signature of funeral director: C.H.Blackman & Son, Inc

(b) Address: 2825 Indep. Blvd. K.C.Mo.

19. (a) 3-4-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3rd year 1940 hour 3 minute 10 P. M.

21. I hereby certify that I attended the deceased from 11-2-39, 19..., to 3-3-40, 19...; that I last saw him alive on 3-3-40, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: EMPHYSEMA, SENILE	
Due to: CHRONIC CARDIAC DECOMPENSATION	
Due to: 9503	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy: See above	

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: P.F. De Maria MD (M. D. or other)

Address: Supt. K.C. Gen. Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39 I X19511

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.....W D Blackman.....

Licensed Embalmer No.....3639.....

P. O. Address.....K. C. Mo.....

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.