

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
 STANDARD CERTIFICATE OF DEATH

12402

Registration District No. 784

Primary Registration District No. 200

State File No. _____

Registrar's No. 482

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Pine Lawn
 (c) Name of hospital or institution:
Greenwich 3718 Jennings Road.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: 24 in hospital or institution (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Veitra I. Mac Glasson
 3. (b) If veteran, name war _____ 3. (c) Social Security No. 497-25-2312

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mary E. Mac Glasson 6. (c) Age of husband or wife if alive 62 years
 7. Birth date of deceased March 16th. 1872
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>11</u>	<u>20</u>	hr. _____ min.

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

10. Usual occupation Decorator

11. Industry or business Unemployed

12. Name ? Mac Glasson
 13. Birthplace Dont Know
 (City, town, or county) (State or foreign country)
 14. Maiden name Dont Know
 15. Birthplace Dont Know
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature W. H. Schmitt
 (b) Address 3603 N. Taylor Ave.
 17. (a) Burial (b) Date thereof 3-9-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation New St. Marcus Cem.

18. (a) Signature of funeral director Prosser Ltd Co.
 (b) Address 3710 N. Grand Blvd.
 19. (a) MAR 8 1940 (b) D. R. Meyer, M.D.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County _____
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3603 N. Taylor Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month March day 6th.
 year 1940 hour 7.20 minute _____ P. M.
 21. I hereby certify that I attended the deceased from 2/21/40
 _____, 19____, to 3/6/40, 19____;
 that I last saw him alive on 3/6/40, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchogenic carcinoma with metastasis into all glands; greatest involvement supraclavicular bilateral
 Due to Secondary: Myocarditis, myocardial failure, inanition, asphyxia; asphyxia caused by loss of air cell area
 Duration 6 mo
 history 2/21/40

Other conditions (include pregnancy within 3 months of death) _____
 Major findings: Of operations 47
 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) _____ (e) Means of injury _____
 23. Signature Dr. Meyer (M. D. or other) _____
 Address 3718 Jennings Rd. Date signed 3/9/40

L.B. Johnson
3718 Johnson
8-9-34
- 9:30 P.M.

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 G. G. Smithers

Licensed Embalmer No. 3916

P. O. Address 3710 N. Grand St.

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.