

OCT 23 1940

Primary Registration District No. 5806-4361

Registrar's No. 50

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County New Madrid

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

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2
(Specify whether)

In this community 2
years, months or days

3. (a) PRINT FULL NAME James Leslie Glass

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race white

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

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

7. Birth date of deceased April 5 1927
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>13</u>	<u>5</u>	<u>25</u>	hr. min.

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

10. Usual occupation Student

11. Industry or business _____

12. Name Leslie Glass

13. Birthplace Genoa
(City, town, or county) (State or foreign country)

14. Maiden name Frances
(City, town, or county) (State or foreign country)

15. Birthplace Genoa
(City, town, or county) (State or foreign country)

16. (a) Informant Leslie Glass

(b) Address Portageville mo

17. (a) Burial (b) Date thereof Oct 1 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Chhurch

18. (a) Signature of funeral director M. Payne

(b) Address Portageville mo

19. (a) 10-9-1940 (b) Mary W. Cook
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid

(c) City or town Portageville
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 30
year 11 hour 20 minute 45 M.

21. I hereby certify that I attended the deceased from Nov 5th 1939 to Sept 30 1940
that I last saw him alive on Sept 29, 1940
and that death occurred on the date and hour stated above

Immediate cause of death _____
Lymphosarcoma
Due to with Cardiac failure
Duration 1 year 3 days

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: none
Of operations Biopsy proved diagnosis
Of autopsy none

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? _____

While at work _____ (Specify type of place)

(e) Means of injury _____

23. Signature P. C. Conrad (M. D. or other) M.D.

Address Portageville, Mo Date signed 10-1-40

528

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32655-**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **609**

Primary Registration District No. **4361**

Registrar's No.

1. PLACE OF DEATH:

(a) County **New Madrid**
(b) City or town **Portageville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **James Lester Glass**

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 **s**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **13** Months **5** Days **25** If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **9** day **30**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death **Lymphosarcoma**
with cardiac failure
Due **Lymphosarcoma**
beginning in suprarenal
gland through metastasis

Other conditions _____
(Include pregnancy within 9 months of death)
Major findings:
Of operations _____
Of autopsy _____

Duration _____
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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature **R. C. Conard** (M. D. or other) **MD**
Address **Portageville, Mo** Date signed **11-20-40**

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

