DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 11 1969

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17466

Registration District No. 124 Primary Registration District No. 5179 Registrar's No. 17 11

1. PLACE OF DEATH:

(a) County CAPE GIRARDEAU

(b) ~~City or town:~~ Rural (Byrd Twp)
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau

(c) City or town Rural (Byrd Twp)
(If outside city or town limits, write "RURAL")

(d) Street No. Route 2
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME JOHN LEANDAR GLADISH

3. (b) If veteran, name war ~~Strong~~ 8 3. (c) Social Security No. None

4. Sex M 0 5. Color or race W 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Strong Gladish 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February (Month) 3 (Day) 1854 (Year)

8. AGE: Years 87 Months 3 Days 0 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Mastin Gladish
13. Birthplace Virginia (City, town, or county) / (State or foreign country)

MOTHER
14. Maiden name Chealem Sanitifer
15. Birthplace Virginia (City, town, or county) / (State or foreign country)

16. (a) Informant's own signature L. A. Gladish
(b) Address Route 2 Jackson Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4-1941 (Month) (Day) (Year)
(c) Place: burial or cremation Gladish Cemetery

18. (a) Signature of funeral director McCombs Farm Plaza
(b) Address Jackson Mo.

19. (a) 5-3-41 (Date received local registrar) (b) D. G. [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3 year 1941 hour 11:30 minute A M.

21. I hereby certify that I attended the deceased from Dec 10, 1938, to May 3, 1941; that I last saw him alive on May 2, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Artero Sclerosis	3 yrs
Due to Chronic Nephritis	1 yr
Due to High Blood Pressure	2 yrs
Other conditions (Include pregnancy within 3 months of death) None	

Major findings: Of operations none

Of autopsy no

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? 120 (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature E. R. Schoger (M. D. or other)

Address Jackson Mo Date signed 5-3-41

(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.

1 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 Thos N Allen

Licensed Embalmer No. 4055

P. O. Address Jackson

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.