

Registration District No. 20

Primary Registration District No. 101

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Richmond Hgts
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Marys Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 Minutes
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis
(c) City or town Overland
(If outside city or town limits, write "RURAL")
(d) Street No. 8817 Windom
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Fred Glover

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

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 _____ years

7. Birth date of deceased Mar 4 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 0 hr. 30 min.

9. Birthplace St Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

12. Name Fred Glover

13. Birthplace St Louis Mo
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Hildebrant

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

16. (a) Informant Mrs Fred Glover

(b) Address 8817 Windom

17. (a) Burial (b) Date thereof 3/5/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Ortmann Funeral Home

(b) Address 9222 Lackland Overland Mo

19. (a) MAR 5 1943 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4
year 1943 hour 5 minute 50 A. M.

21. I hereby certify that I attended the deceased from March 4
1943 to March 4 1943

that I last saw him alive on March 4 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory infant (7 months)

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

(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 [Signature] (M.D. or other)

Address 8924 S. Charles St Date signed 3/4/43

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

MOTHER, FATHER

W 5006 7-11

APR 15 1943

96 13 1

Duration

20 min

PHYSICIAN

Underline the cause to which death should be charged statistically.

St Louis Co, Mo

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.

not embalmed

Signed..... *Ed C. Ortman*

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.