

FILED DEC 29 1943

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. James Mo**

(b) City or town **St. James Mo**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **BARNES HOSPITAL**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **Edgar**

(c) City or town **Mattoon**  
(If outside city or town limits, write "RURAL")

(d) Street No. **2605 7th Street NW**  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) **PRIME FULL NAME** **Glenn Emma Inayes**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **FRANK MAYER** 6. (c) Age of husband or wife if alive **59?** years

7. Birth date of deceased **July 4-1884**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DEC.** day **11**  
year **1943** hour **1** minute **30 AM**

21. I hereby certify that I attended the deceased from **DEC. 8** 19**43** to **DEC. 11** 19**43**  
that I last saw him alive on **Dec. 11** 19**43**  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<b>59</b>	<b>3</b>	<b>7</b>	hr. _____ min. _____

Immediate cause of death **Heart failure**

Due to **arteriosclerotic heart disease**

9. Birthplace **Hamilton Canada**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

Other conditions **diabetes, albuminuria**  
(Include pregnancy within 3 months of death)

Major findings: **glomerulonephritis**

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name **Andrew Phelan**

13. Birthplace **New York**  
(City, town, county) (State or foreign country)

14. Maiden name **Margaret Gear**

15. Birthplace **Hamilton Canada**  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant **J. F. Bredich**

(b) Address **Mattoon**

17. (a) **Removal** (b) Date thereof **12-11-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mattoon, Illinois**

18. (a) Signature of funeral director **Albert H. Hoppe, Inc.**

(b) Address **4700 Washington Blvd.**

19. (a) **DEC 14 1943** (b) **J. F. Bredich**  
(Date received local registration) (Registrar's signature)

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 **J. F. Bredich** (M. D. or other) **MD**  
Address **BARNES HOSPITAL** Date signed **12/11/43**

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

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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 *Robert G. Hoff*

Licensed Embalmer No. *2971*

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.