

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

2  
42  
7-39  
K32873

FILED FEB 9 1944  
Registration District No. 245

Primary Registration District No. 3047

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Newton

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

(c) Name of hospital or institution:  
St John Street  
(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 Newton

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

(d) Street No. St John Street  
(If rural, give location)

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

3. (a) PRINT FULL NAME ANNA H. Glenister

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24  
year 1943 hour 8 minute 10 A.M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife George Glenister 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 25 1850  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 20 1943, to Dec 24 1943  
that I last saw her alive on Dec 24 1943  
and that death occurred on the date and hour stated above.

8. AGE: Years 92 Months 11 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Cerebral hemorrhage  
ret. side Duration 5 day

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

Due to arterio sclerosis

10. Usual occupation Housewife

Due to Senility

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

12. Name No Record

Major findings: g3a1

13. Birthplace No England  
(City, town, or county) (State or foreign country)

Of operations \_\_\_\_\_

14. Maiden name No Record

Of autopsy \_\_\_\_\_

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

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Annie Neill

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

(b) Address Neosho Missouri

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

17. (a) Burial (b) Date thereof 12-27-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence \_\_\_\_\_

(c) Place: burial or cremation 1007 Cemetery

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

18. (a) Signature of funeral director R. B. Berman

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(b) Address Neosho Missouri

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

19. (a) 1-26-1944 (b) Wesley Thompson  
(Date received local registrar) (Registrar's signature)

23. Signature R. C. Lawson (M. D. or other) \_\_\_\_\_  
Address Neosho Mo Date signed 1/24/43

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

MOTHER FATHER

**RECEIVED** 1-5-44

District Health Officer No. ....

District File Number 144-10 .....

Date Filed 1-7-44 .....

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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.....

Licensed Embalmer No. 2689 .....

P. O. Address Keokuk Mo .....

**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.**