

No. 2  
1-2-43  
1-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **11897**

X35697

FILED APR 1 1944

Primary Registration District No. **6047**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **ST CHARLES - CTY.**  
(b) City or town **ROUTE # 2**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **AT HOME /**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **3 YEARS**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **ST CHARLES**  
(c) City or town **RURAL ROUTE # 2**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **ROBERT ALEXANDER GLENN**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **ELIZABETH GLENN** 6. (c) Age of husband or wife if alive **DECEASED** years \_\_\_\_\_

7. Birth date of deceased **MAR 27 1864**  
(Month) (Day) (Year)

8. AGE: Years **79** Months **11** Days **19** If less than one day **70 hr. 05 min.**

9. Birthplace **CLAYTON MO**  
(City, town, or county) (State or foreign country)

10. Usual occupation **FARMER**

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

12. Name **SAMPBELL GLENN**

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

14. Maiden name **UNKNOWN**

15. Birthplace **TIPPERARY IRELAND**  
(City, town, or county) (State or foreign country)

16. (a) Informant **St Charles Co. Registrar**

(b) Address **St Charles Co. Route 2**

17. (a) **BURIAL** (b) Date thereof **MAR 23 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **STEEPDINAND, FLORISSANT MO**

18. (a) Signature of funeral director **Walter Boyles**

(b) Address **6736 Clayton Rd**

19. (a) **3-25-44** (b) **By Linda S. Feristell**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAR** day **20** year **1944** hour \_\_\_\_\_ minute **8** P. M.

21. I hereby certify that I attended the deceased from **March 17 1944** to **March 20 1944** that I last saw him alive on **March 17 1944** and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial infarction**  
Due to **arteriosclerosis**

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) **9321**

Major findings: Of operations \_\_\_\_\_

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

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) (a) Means of injury \_\_\_\_\_

23. Signature **Charles W. Atree** (M. D. or other) \_\_\_\_\_

Address **2222 1/2** Date signed \_\_\_\_\_

Duration **4 days**  
**3 yrs**  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

**RECEIVED**

**District Health Officer: No. 9,**

District File Number \_\_\_\_\_

Date Filed 3-31-44

**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 W. Wilkins

Licensed Embalmer No. 3573

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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 305Primary Registration District No. 6047

Registrar's No. ....

## 1. PLACE OF DEATH:

- (a) County 5 + Charles (Cura)  
 (b) City or town Wentzville  
 (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 NAMERobert A. Glenn

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 w

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

7. Birth date of deceased mar 27  
(Month) (Day) (Year)

8. AGE: Years 79 Months 11 Days 1 If less than one day, min.

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

10. Usual occupation

11. Industry or business

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)
- Gertrude S. Foristell
- 
- (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) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mar Day 20  
 year 1944 hour 11 minute 30 M.

21. I hereby certify that I attended the deceased from....., 19.....;  
 that I last saw him..... after on....., 19.....;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)Major findings:  
Of operations.....

Of autopsy.....

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

11897