

FILED MAY 10 1944

Registration District No. **270**

Primary Registration District No. **5909**

1. PLACE OF DEATH:
(a) County **Pemiscot**
(b) City or town **Steele Rural Jct**
(c) Name of hospital or institution: **Parson's**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 days** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Pemiscot**
(c) City or town **Steele (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 **FLORENCE LEE GLASPER**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **23**
year **1944** hour **16** minute _____ P. M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex **MALE** 5. Color or race **NEGRO**
6. (a) Single, widowed, married, divorced **0**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)
7. Birth date of deceased **April 15 1944**
(Month) (Day) (Year)

Immediate cause of death **Not known**
No attending physician
Duration _____

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

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

10. Usual occupation _____
11. Industry or business _____
12. Name **EARNEST GLASPER**
13. Birthplace **GOLDEN LAKE ARK.**
(City, town, or county) (State or foreign country)
14. Maiden name **CELIA HOLMES**
15. Birthplace **Burlington TENN.**
(City, town, or county) (State or foreign country)

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 statistically.

16. (a) Informant **Earnest Glasper**
(b) Address **Steele Mo**
17. (a) **Burial** (b) Date thereof **4-24-1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **County Farm**
18. (a) Signature of funeral director **Dewey Randolph, Day**
(b) Address **North Mo**
19. (a) **4-24-1944** (b) **Jessie N. Mark**
(Date received local registrar) (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 **Fred. Ogrove** (M. D. or _____) **MD**
Address **Carthage Mo** Date signed **4/24/44**

MOTHER FATHER

4-44-91

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.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 270 Primary Registration District No. 5909

1. PLACE OF DEATH:
(a) County Pemiscot
(b) City or town Rural Little Prairie 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) (Specify whether

3. (a) PRINT FULL NAME Eddie Lee Gasper
3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

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

7. Birth date of deceased April 14 1944
(Month) (Day) (Year)

8. AGE: Years Months Days (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

Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director..... (b) Address

19. (a) (Date received local registrar) (b) (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 April Day 23 year 1944 hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... 19.....; that I last saw him..... alive on..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Not known Duration

There was no attending physician in this case. The child was only eight days old and no coroners inquest was deemed necessary.

I have not the least idea of the cause of death

Other conditions (Include pregnancy within 3 months of death)

The prosecuting attorney was consulted and he instructed me as health officer to make up the death certificate

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

(a) Accident, suicide, or homicide (specify)..... 2000

(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 Fred L Ogilvie. MD (M. D. or other)..... Address..... Date signed.....

SUPPLEMENTARY

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

MOTHER FATHER

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

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