

FILED SEP 13 1944

Registration District No. **387**

Primary Registration District No. **4515**

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

1. PLACE OF DEATH:

(a) County Sullivan

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

(c) Name of hospital or institution: Simpson Hospital
(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 NAME Homer Duane Glidewell

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

4. Sex Male 5. Color or Race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug. 12 1941
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 2 hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Homer Glidewell

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

14. Maiden name Mary Hardman

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

16. (a) Informant Homer Glidewell
(b) Address Milan Mo

17. (a) _____ (b) Date thereof 8-12-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Deep Springs

18. (a) Signature of funeral director Sharon Farned Green

(b) Address Milan Mo

19. (a) Sept 4 1944 (b) Mrs. P. D. Green
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan ¹⁰⁵

(c) City or town Milan ⁰
(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 Aug day 12
year 1944 hour 3 minute 17 P.M.

21. I hereby certify that I attended the deceased from Aug 12
1944 to Aug 12 1944;
that I last saw him alive on Aug 12 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth

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.

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 2

23. Signature E. Simpson (M. D. or other) 20
Address Milan Date signed 8-12-44

RECEIVED

District Health Officer No. 10

District File Number 9-44-1574

Date Filed SEP-12-1944

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 Wright Schauer

Licensed Embalmer No. 2667

P. O. Address Milan, 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.