No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 6 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29344

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8237

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G. Phillips Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community 10 years years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 17
(c) City or town St. Louis, 9 21
(If outside city or town limits, write "RURAL")
(d) Street No. 3160 School St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME George Glenn

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 1

5. Color or race Negro

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Anna Glenn

6. (c) Age of husband or wife if alive Dec'd years

7. Birth date of deceased Unavailable Abt. 1872 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
About 72	-	-	hr. min.

9. Birthplace Madison County (City, town, or county) Tennessee (State or foreign country)

10. Usual occupation Coal-dealer (retail)

11. Industry or business as above

MOTHER FATHER

12. Name West Glenn

13. Birthplace Madison County (City, town, or county) Tennessee (State or foreign country)

14. Maiden name Mollie Dollison

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

16. (a) Informant Alice Wilson
(b) Address 3160 School St.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-27-1944 (Month) (Day) (Year)
(c) Place: burial or cremation Jackson Tennessee

18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney Ave.

19. (a) SEP 27 1944 (Date received local registrar) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 24, year 1944 hour 8 minute 35 P. M.

21. I hereby certify that I attended the deceased from September 21, 1944 to September 24, 1944; that I last saw him alive on September 24, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Degenerative Heart Disease with cardiac failure	Unk.
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] (M. D. ~~coroner~~)
Address 3600 Whittier Date signed 9/26/44

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by ~~xx.xxbyxx~~ Thomas J. Gates ~~Registered Apprentice No.x~~ ~~xwhile under my personal supervisionx~~

Signed [signature]

Licensed Embalmer No. 4259

P. O. Address 4107 Finney Avenue

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.