

No. 2
8-13
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 30 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29587

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7998

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Luke's 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Greene
(c) City or town Rural - White Hall
(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 _____

3. (a) PRINT FULL NAME Audrey McGlasson

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased November 19 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
9 29 hr. _____ min.

9. Birthplace White Hall Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

12. Name Richard McGlasson

13. Birthplace Unknown Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Maudie Leach

15. Birthplace White Hall, Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Maudie McGlasson

(b) Address White Hall, Ill.

17. (a) Removal (b) Date thereof 9-19-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation White Hall, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) SEP 18 1944 (b) J. P. Hedrick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 18
year 1944 hour 3:30 minute A. M.

21. I hereby certify that I attended the deceased from Sept.
14, 1944, to Sept.
17, 1944,
that I last saw him alive on Sept. 17, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Thymogaster Tuberculosis
Due to Lungs not affected

Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
1/4

Major findings: _____
Of operations _____
Of autopsy None
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) _____ (Means of injury) _____

23. Signature A. M. Klum (M. D. or other) M.D.
Address 495 1/2 Maryland Ave. Date signed 9/18/44

(Licensed Embalmer's Statement on Reverse Side) St. Louis, Mo

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

MOTHER FATHER

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 *Alvin G. Hoppe*

Licensed Embalmer No. *2971*

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.