

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

FILED OCT 11 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

30867

Registration District No. 120

Primary Registration District No. 5444

Registrar's No. 104

1. PLACE OF DEATH:

(a) County Gentry
(b) City or town Central Albany Township
(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 1
In this community 70 years
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Benjamin Thomas Glasco
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 7 1860
(Month) (Day) (Year)

8. AGE: Years 84 Months 4 Days 22 If less than one day hr. min.

9. Birthplace Tena Haute Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Richard Glasco
13. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Millie Berra
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Beldon Park
(b) Address Albany Mo. R.F.D.

17. (a) Burial (b) Date interred Oct 11 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hendon

18. (a) Signature of funeral director Leifert Bros
(b) Address Albany Mo

19. Oct 5-1944 (Date received local registrar) Frank H. Webster (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gentry 38
(c) City or town Albany Mo 3
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29
year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased body after
death 19____; that I last saw h. alone on 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration _____

Due to _____
Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: 93d
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:

(c) 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 Frank A. Barnes (M. D. or other) DO
Address King City Mo Date signed 9/29/44

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

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 me
....., Registered Apprentice No.....
working under my personal supervision.

Signed Edward Burke

Licensed Embalmer No. 3329

P. O. Address Albany 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.

Registration District No. 120 Primary Registration District No. 5444

1. PLACE OF DEATH:
(a) County Gentry
(b) City or town Sumner Athens 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)

3. (a) PRINT FULL NAME Benjamin J Glasco

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

4. Sex M 5. Color or race W

6. (b) Name of husband or wife Jennie Steele 6. (c) Age of husband or wife if alive 83 years

Birth date of deceased May 7 (Month) (Day) (Year)

8. AGE: Years 84 Months _____ Days _____ If less than one day _____ min.

9. Birthplace _____ (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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. Oct 16-1944 (Date received local registrar) (b) James T. McIntosh (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 Sept 9
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 _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

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)

(e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

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

308107