

FILED FEB 16 1945

Registration District No. 133

Primary Registration District No. 3022

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

1. PLACE OF DEATH:  
 (a) County Harrison  
 (b) City or town Bethany City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Walker Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 9 Days  
(Specify whether  
 In this community Nine Days  
years, months or days)

3. (a) PRINT FULL NAME John Armstrong Glenn  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife Elizebeth Jane Glenn Deceased 6. (c) Age of husband or wife if 30 years

7. Birth date of deceased June 6 1855  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>89</u>	<u>6</u>	<u>6</u>	hr. _____ min.

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

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

12. Name Clinton Glenn

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

14. Maiden name Jinnie Holister

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

16. (a) Informant Chas Walter

(b) Address Martinsville

17. (a) Burial (b) Date thereof Dec 13 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Magee Cemetery

18. (a) Signature of funeral director W. S. Noble

(b) Address New Hampton Mo

19. (a) 114-45 (b) Zola Burres  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Harrison 41  
 (c) City or town Martinsville 0  
(If outside city or town limits, write "RURAL") 0  
 (d) Street No. City  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No) 0  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 12  
 year 1944 hour 5 minute 20 a. M.

21. I hereby certify that I attended the deceased from Nov. 20  
 1944 to Dec. 12 1944  
 that I last saw him alive on Dec. 12 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: g 20  
 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) Manner of injury 2

23. Signature Ralph Walker (M. D. or other) 20

Address Bethany, Mo Date signed 1/4/45

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**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 *W G Noble*.....

Licensed Embalmer No. *2904*.....

P. O. Address *New Hampton 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.**