

FILED APR 28 1945

Primary Registration District No. **1000**

Registrar's No. **449**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Week (Hospital)**
(Specify whether
In this community **Lifetime**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **3001 So. 28th. St.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **15**
year **1945** hour **10** minute **30 P.M.**

21. I hereby certify that I attended the deceased from
Apr 8 1945 to **Apr 15 1945**
that I last saw him alive on **Apr 15 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death
Coronary Thromb
Due to **Arterio Sclerosis**

Duration

1 wk

Other conditions
Gas Anger
(Include pregnancy within 3 months of death)
Engorgement of heart

7 days

Major findings:
Of operation
None
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?

(Specify type of place)
While at work _____ (e) Means of injury _____
23. Signature **Robert J. Tucker** (M. D. or other)
Address **620 Marces** Date signed **4/16/45**

3. (a) PRINT FULL NAME **Joseph Albert Gloggner**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **491-10-1329**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Ruth Margaret** 6. (c) Age of husband or wife if alive **52** years

7. Birth date of deceased **September 23 1882**
(Month) (Day) (Year)

8. AGE: Years **62** Months **6** Days **22** If less than one day
hr. _____ min. _____

9. Birthplace **St. Joseph Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Machinist**

11. Industry or business **Acme Machine Shop**

12. Name **Joseph A. Gloggner**

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

14. Maiden name **Anna Unknown**

15. Birthplace **Unknown Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ruth M. Gloggner**

(b) Address **3001 So. 28th. St.**

17. (a) **Burial** (b) Date thereof **Apr. 18, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olivet Cemetery**

18. (a) Signature of funeral director **Newman W. Sidenfaden**

(b) Address **1802 Union St. St. Joseph, Mo.**

19. (a) **April 16, 45** (b) **Robert J. Tucker**
(Date received local registrar) (Registrar's signature)

1377

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

Heruwan W. S. deufadun

Licensed Embalmer No.

2728

P. O. Address

St. Joseph 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.