S. No. 2
M--8-43
. 5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 16 1945
Registration District No. 374

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18499
Primary Registration District No. 3746273
Registrar's No.

1. PLACE OF DEATH:
(a) County: Worth
(b) City or town: Rural, Fletchall Twnd
(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) 1
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Worth 113
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Grant city Mo.
(If rural, give location)
(e) Citizen of foreign country? no. 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Wellington E. 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 Married
6. (b) Name of husband or wife Nellie Glenn
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased May (Month) 2 (Day) 1866 (Year)

8. AGE: Years	Months	Days	If less than one day
78	10	27	hr. min.

9. Birthplace Worth Co. (City, town, or county) Mo. U (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
MOTHER FATHER
12. Name William Glenn
13. Birthplace O (City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Montgomery
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Nellie Glenn
(b) Address Grant city
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-45 (Month) (Day) (Year)
(c) Place: burial or cremation Honey Grove
18. (a) Signature of funeral director Frank C. Dunfee
(b) Address Grant City, Mo.
19. (a) Apr. 11 1945 (Date received local registrar) (b) Maxine Pinehart (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 29
year 1945 hour 12 minute 05 P. M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Thrombosis	
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 Luther Neal M.D. (M. D. or other)
Address Grant City Date signed 3-31-45

1385

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11
District File Number
Date Filed

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 Josh C Dunfee

Licensed Embalmer No. 3252

P. O. Address Grant City, 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.