. S. No. 2
M—8-43
v. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

25673

State File No.

FILED SEP 14 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7894

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

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17
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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:
3505a Park Ave 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community 40 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17 18
(If outside city or town limits, write "RURAL")

(d) Street No. 3505a Park Ave 9
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME John H. Glassco

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Ollie Glassco

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased November (Month) 26th (Day) 1883 (Year)

8. AGE: Years ~~68~~ 61 | Months 9 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Marshaltown (City, town, or county) Iowa 1 (State or foreign country)

10. Usual occupation Personal Man

11. Industry or business Mayfair & Lennox Hotel

FATHER
12. Name William W. Glassco
13. Birthplace (City, town, or county) Kentucky 1 (State or foreign country)

MOTHER
14. Maiden name Belle M. Watt
15. Birthplace (City, town, or county) Pennsylvania 1 (State or foreign country)

16. (a) Informant Mrs Ollie Glassco Wife
(b) Address 3505a Park Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10th 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Lakewood Park Cemetery

18. (a) Signature of funeral director Peetz Bros
(b) Address 3029 Lafayette Ave

19. (a) SEP 9 1945 (Date received local registrar) (b) J. T. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 8th year 1945 hour 8:00 minute A M.

21. I hereby certify that I attended the deceased from Feb 2, 1944 to Sept 8, 1945 that I last saw him alive on Sept 7, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris — Duration Several months

Due to Hypertension and chronic myocarditis — Several years

Due to

Other conditions (Include pregnancy within 3 months of death) 93 d

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 H. Louis Schlueter M.D. ~~or other~~

Address 2200 Chouteau Ave Date signed 9-9-45

(Licensed Embalmer's Statement on Reverse Side)

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 Frank J. Owens

Licensed Embalmer No. 2245

P. O. Address 3024 Lafayette

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.