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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 9 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38635

State File No. _____

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10268**

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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days**
In this community **23 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1545 Love Joy**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Leo Glaze**
3. (b) If veteran, name war **none**
3. (c) Social Security No. **487-18-3832**
4. Sex **Male** 5. Color or race **col.**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Cora Glaze**
6. (c) Age of husband or wife if alive **44** years
7. Birth date of deceased **November 25, 1903**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov.** day **27**
year **1946** hour **9** minute **35 A.M.**
21. I hereby certify that I attended the deceased from **11-25** 19 **46** to **11-27** 19 **46**
that I last saw him alive on **Nov. 27** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
Duration? **Undet.**

8. AGE: Years **43** Months **0** Days **2**
If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions **None**
(Include pregnancy within 3 months of death)

9. Birthplace **Little Rock Arkansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Maintenance Portland Cement Co.**

11. Industry or business _____
12. Name **Peter Glaze**
13. Birthplace **unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **UNKNOWN**
(City, town, or county) (State or foreign country)
15. Birthplace **unknown**
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy **No**
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Cora Glaze**
(b) Address **1545 Love Joy Lane**
17. (a) **Burial** (b) Date thereof **12-3-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation **Calvary**
18. (a) Signature of funeral director **[Signature]**
(b) Address **3506 Franklin Avenue**
19. (a) **DEC 7 1946** **J. F. Buddeck**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **H. J. Erwin** (M. D. or other) _____
Address **2601 Whittier** Date signed **11/27/46**

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.....

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

Signed James A. Johnson
Licensed Embalmer No. 3522
P. O. Address 3506 Franklin

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.