

1. PLACE OF DEATH:
(a) County **Barry**
(b) City or town **Rural Sugar Creek Twp.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2 mi. S. of Seligman, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1** (Specify whether
In this community **2 yrs.** years, months or days)

3. (a) PRINT FULL NAME **Clarence Arthur Glover**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Div**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive **29** years
7. Birth date of deceased **June 29, 1876**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	70	7	13	hr. _____ min.

9. Birthplace **Troy, Tenn.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Farming**

MOTHER FATHER
12. Name **Hiram Van Glover**
13. Birthplace **Charlotte, N. C.**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Hugh Garinton**
(b) Address **Troy, Tenn.**

17. (a) **removal** (b) Date thereof **Feb. 13-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Union City Tenn**

18. (a) Signature of funeral director **Koon Funeral Home**
(b) Address **Cassville, Mo.**

19. (a) **Feb-13-1947** (b) **Grace Williams**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Barry**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Seligman, Rt. 1**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **12**
year **1947** hour **about 4** minute **A.** 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 **apparently a heart attack**

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: Of operations **950**

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) Means of injury **3**

23. Signature **G. P. Buchanan** (M. D. or other)
Address **Monett, Mo.** Date signed **2-12-47**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 6,

District File Number 247-232

Date Filed FEB 17 1947

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 J. C. Canada
Licensed Embalmer No. 4196
P. O. Address Cassville, 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.

Registration District No. 11

Primary Registration District No. 5043

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Rural
(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)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Clarence A. Glover

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 divorced

6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive unknown

7. Birth date of deceased June 29
(Month) (Day) (Year)

8. AGE: Years 70 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) March 14-47 (b) Grace Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month March Day 14 Year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ at _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 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) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY 2

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-3871