

No. 2  
8-43  
5-17-30  
X37823

FILED AUG 4 1947

State File No. \_\_\_\_\_

Registration District No. 135

Primary Registration District No. 5497

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Harrison

(b) City or town Ridgeway Special Merit  
(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 46 yrs.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Harrison <sup>541</sup>

(c) City or town Ridgeway <sup>0</sup>  
(If outside city or town limits, write "RURAL") <sup>0</sup>

(d) Street No. \_\_\_\_\_ (If rural, give location) \_\_\_\_\_

(e) Citizen of foreign country? no (Yes or No) no  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Etta Hanna Glenn

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23  
year 1947 hour 1:42 minute A. M.

21. I hereby certify that I attended the deceased from April 15  
1947, to June 8, 1947  
that I last saw her alive on June 8, 1947  
and that death occurred on the date and hour stated above.

4. Sex T. /

5. Color or race W

6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Richard E. Glenn Deceased

6. (c) Age of husband or wife if married \_\_\_\_\_ years

7. Birth date of deceased 1-23-1873  
(Month) (Day) (Year)

Immediate cause of death Chronic Myocarditis undef  
Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day

74 4 29 hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Bright's disease undef  
(Include pregnancy within 3 months of death)

9. Birthplace Decatur Co. Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation Horse Keeper

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy 93D

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

12. Name William McDougall

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

14. Maiden name Sarah King

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

16. (a) Informant Vernon Glenn

(b) Address Ridgeway Mo

17. (a) Burial (b) Date thereof June 25 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Morris Chapel

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Did injury occur in or about home, on farm, in industrial place, in public place? 2

18. (a) Signature of funeral director W. P. Roggels

(b) Address Ridgeway Mo

19. (a) 6-3-47 (b) L. H. Brewer  
(Date received local registrar) (Registrar's signature)

While at work \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature D. G. Reid (M. D. or other) RD

Address Bellway Mo Date signed 6-25-47

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

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

**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 *Robert R. Bagers*  
Licensed Embalmer No. *35-76*  
P. O. Address *Ridgewood*

**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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. AugRegistration District No. 135Primary Registration District No. 5497Registrar's No. 40

## 1. PLACE OF DEATH:

(a) County Harrison  
 (b) City or town Ridgeway  
 (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 NAMEEtha H. Glenn3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_

4. Sex F 5. Color of race W 6. (a) Single, widowed, married,  
divorced wid

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

7. Birth date of deceased Jan 23  
(Month) (Day) (Year)

8. AGE: Years 74 Months 4 Days \_\_\_\_\_ (If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_)

9. Birthplace Iowa  
(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) 6-3-47 (b) L. Libremus  
(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 Aug Year 1947  
 day 23 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration \_\_\_\_\_

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 sta-  
 tistically.

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

SUPPLEMENTARY

MOTHER FATHER

23973