No. 2
1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUL 21 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25556

Registration District No. 318 | Primary Registration District No. 1003 | Registrar's No. 6484

1. PLACE OF DEATH:
(a) County: ST LOUIS
(b) City or town: (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BARNES HOSPITAL (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 22 DAYS (Specify whether years, months or days)
In this community: 22 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State: ILL (b) County: ST CLAIR
(c) City or town: CASEYVILLE, ILL. R.R.1 (If outside city or town limits, write "RURAL")
(d) Street No.: R.R. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

999 11 0 2

3. (a) PRINT FULL NAME: FRIEDA GLENN
3. (b) If veteran, name war: NO
3. (c) Social Security No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: MARRIED
6. (b) Name of husband or wife: OSCAR
6. (c) Age of husband or wife if alive: 61 years
7. Birth date of deceased: NOV (Month) 21 (Day) 1889 (Year)

8. AGE: Years: 57 | Months: 7 | Days: 17 | If less than one day: hr. min.

9. Birthplace: WATERLOO (City, town, or county) ILL (State or foreign country)
10. Usual occupation: HOUSEWIFE
11. Industry or business:
MOTHER FATHER
12. Name: HENRY YEAGER
13. Birthplace: UNKNOWN (City, town, or county) (State or foreign country)
14. Maiden name: UNKNOWN
15. Birthplace: " " (City, town, or county) (State or foreign country)
16. (a) Informant: Bertha Owens
(b) Address: 1027 N. 38th St.
17. (a) (Burial, cremation, or removal) E. ST LOUIS (b) Date thereof: 7 8 1947 (Month) (Day) (Year)
(c) Place: burial or cremation: E. ST. LOUIS, ILL
18. (a) Signature of funeral director: Harry Rolens
(b) Address: 417 N. 8 St. E. St. Louis Ill.
19. (a) (Date received local registrar) JUL 9 1947 (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: JULY day: 8 year: 1947 hour: 10 minute: 55 A.M.
21. I hereby certify that I attended the deceased from June 16, 1947 to July 8, 1947 that I last saw her alive on July 8, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cirrhosis of the liver	5 yrs
Due to:	
Due to:	
Other conditions: Diabetes mellitus, hypertension (Include pregnancy within 3 months of death)	5 yrs

Major findings:
Of operations:
Of autopsy: Cirrhosis of the liver

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN: Underline the cause of 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: David T. Graham (M. D. or other) MD
Address: Barnes Hosp. Date signed: 8 July 47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side) DAVID T. GRAHAM

6184

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

Signed Frank Prokopf

Licensed Embalmer No. 4354

P. O. Address St. Louis 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.

S. No. 2B
5M—3-45
I. X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. 1003 Registrar's No. 6484

SUPPLEMENTARY

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:
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill (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

3. (a) PRINT FULL NAME Frieda Glenn

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

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

6. (b) Name of husband or wife

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

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

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

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 8
year 47 hour minute 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 Cancer - primary

Due to site unknown

Due to

Other conditions Cirrhosis of liver
(Include pregnancy within 3 months of death)
Diabetes Mellitus

Major findings:
Of operations
Of autopsy 55E

Duration

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 J. R. Bradley (M. D. or other)

Address Date signed

S-25556