S. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39924

FILED DEC 6 1947

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10778

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

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: 6583 Pernod Ave.
(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 Mo. (b) County 000

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

(d) Street No. 6583 Pernod Ave. 9
(If rural, give location) 0

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

If yes, name country

3. (a) PRINT FULL NAME MARY E. MacGLASSON

3. (b) If veteran, name war None

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Late Vertra I.

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

7. Birth date of deceased Dec. (Month) 18 (Day) 1878 (Year)

8. AGE: Years 68 Months 11 Days 5 If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Jerry M. Phillips
13. Birthplace Charleston (City, town, or county) No. Carolina (State or foreign country)

MOTHER
14. Maiden name Cecelia Johnstone
15. Birthplace Charleston (City, town, or county) No. Carolina (State or foreign country)

16. (a) Informant Warren H. Schneider
(b) Address 6583 Pernod Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-47 (Month) (Day) (Year)
(c) Place: burial or cremation Resurrection Cem.

18. (a) Signature of funeral director Kriegshauser Und. Co.
(b) Address 4238 So. Kingshighway Bl.

19. (a) NOV 24 1947 (Date received local registrar) (b) J.F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 23
year 1947 hour 8:45 minute P. M.

21. I hereby certify that I attended the deceased from June 8, 1947 to Nov. 23, 1947
that I last saw her alive on Nov. 23, 1947, 19
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency
my cardiitis
Due to arteriosclerosis
Chronic nephritis
Due to (cardio-nephritis)

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None.

Duration

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 0

23. Signature Walter C. G. Kuchner (M. D. or other)

Address 508 N. Grand Blvd. Date signed 11/24/47

Jefferson City Printing Co. (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.....Richard H. Stoversand.....

Licensed Embalmer No.....4007.....

P. O. Address.....

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. 21
M 2-3-45
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. Dec

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10776

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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Mary E. Mac Glasson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or 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 Dec (Month) 18 (Day) 1879 (Year)

8. AGE: Years 68 Months 4 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Ill. (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) Nov. 24-1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature) DEC 1 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 23 year 1947 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 — 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 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 (M. D. or other)

Address Date signed

SUPPLEMENTARY