

FILED NOV 25 1947

State File No. _____

Registration District No. 137

Primary Registration District No. 6076

Registrar's No. 2327

1. PLACE OF DEATH: St. Louis
 (a) County St. Louis
 (b) City or town Overland, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Penn's Nursing Home 4
 (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, Missouri 17
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5217 Theodosia Ave 4
 (If rural, give location)
 (e) Citizen of foreign country? No 1 (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Francis T. Glickert
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color of race W
 6. (a) Single, widowed, married, divorced 2
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 13, 1871
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>5</u>	<u>10</u>	hr. _____ min. _____

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

10. Usual occupation retired

11. Industry or business _____

MOTHER FATHER
 12. Name Francis T. Glickert
 13. Birthplace Rolla, Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Guitarr
 15. Birthplace Louisiana
 (City, town, or county) (State or foreign country)

16. (a) Informant Leo M. Glickert
 (b) Address 5217 Theodosia Ave

17. (a) burial (b) Date thereof 11-13-1947
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Harrigan & Shearan
 (b) Address 4415 Washington Bl.

19. (a) 11-13-47 (b) Gene Sharp
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 10th
 year 1947 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from November 4th
October 21 1947 to Nov 10 1947
 that I last saw him alive on November 9 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cardiac insufficiency (failure) 2 days
 Due to auricular fibrillation 1 mo.
 Due to arteriosclerotic Cardio-vascular Renal disease 2 years
 Other conditions (1) Blind (2) senile dementia
 (Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
 Of operations 1310
 Of autopsy _____

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?
 While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature Lewis Littmann (M. D. or other) MD
 Address 8231 Clayton Rd Date signed 11/12/47

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

8131
Elmer R. Caldwell

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 Elmer R. Caldwell

Licensed Embalmer No. 4077

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.