

S. No. 2
M-5-43
5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6202
State File No. 2360

FILED MAR 15 1948
Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2360

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis Childrens Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 mos 15 day
(Specify whether years, months or days)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Glenna Rae Cole

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 Single

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

7. Birth date of deceased November 10 1941
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 3 26 hr. min.

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

10. Usual occupation Child

11. Industry or business _____

12. Name Glenn Coe

13. Birthplace Cheyenne Wells Colorado
(City, town, or county) (State or foreign country)

14. Maiden name Lena Turner

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

16. (a) Informant Glenn Coe

(b) Address Mechanicsburg, Ill.

17. (a) Removal (b) Date thereof 3-7-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mechanicsburg, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) MAR 8 1948 (b) J. F. Bredenk
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6
year 48 hour 9 minute 15 A.M.

21. I hereby certify that I attended the deceased from 5-20-47 to 3-6-48
and that I last saw her alive on 3-6-48
and that death occurred on the date and hour stated above.

Immediate cause of death chronic glomerulonephritis, nephrotic state
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? _____

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

23. Signature Gilbert B. Fisher (M. D. or other) _____
Address _____ Date signed _____

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

MOTHER FATHER

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..... *Blair 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.