

FILED OCT 23 1948

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35107

State File No. ....

Registration District No. 377

Primary Registration District No. 6076

Registrar's No. 2046

1. PLACE OF DEATH:

(a) County St. Louis St. Louis Rural

(b) City or town St. Louis

(c) Name of hospital or institution State Training School 2  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution months 27 days  
(Specify whether years, months or days)

In this community 1 yr 10 months 12 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

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

(d) Street No. Bellefontaine Road  
(If rural, give location)

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

If yes, name country: .....

3. (a) PRINT FULL NAME GLENN, William

3. (b) If veteran, name war: .....

3. (c) Social Security No. ....

4. Sex male ( ) 5. Color or race white

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

6. (b) Name of husband or wife: .....

6. (c) Age of husband or wife if 1948

7. Birth date of deceased November 9 1946  
(Month) (Day) (Year)

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

1 10 12 9 hr. 14 min.

9. Birthplace St. Louis, Mo Missouri ( )  
(City, town, or county) (State or foreign country)

10. Usual occupation: .....

11. Industry or business: .....

12. Name William C. Glenn

13. Birthplace Jefferson City Mo 0  
(City, town, or county) (State or foreign country)

14. Maiden name Genevieve Kansas

15. Birthplace St. Louis Mo 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Records of State Training School

(b) Address: .....

17. (a) BURIAL (b) Date thereof SEP 22 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SUNSET BURIAL PK. C. HOFFMEISTER COLONIAL MORT

18. (a) Signature of funeral director: .....

(b) Address 6464 CHAPPEWA ST

19. (a) 9-21-48 (b) Carl G. Clayton  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 21 year 1948 hour 9 minute 17 M.

21. I hereby certify that I attended the deceased from June 25 1948 to Sept 21 1948  
and that I last saw him alive on Sept 1, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: Typhoid Pneumonia

Due to: .....

Due to: Meningitis

Other conditions (Include pregnancy within 3 months of death): .....

Duration 10 days

PHYSICIAN

Major findings: Of operations: .....

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) (a) Means of injury: .....

23. Signature Edward P. Webb (M. D. or other) 0

Address State Training School Date signed 9/21/48

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

---

---

**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.

*Not embalmed*

Signed

*J. F. Hehl*

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

..... 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. NovRegistrar's No. 2216Registration District No. 317Primary Registration District No. 6076

## 1. PLACE OF DEATH:

(a) County St Louis  
 (b) City or town Nov  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: State Training School  
 (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 NAME William Glenn

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

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

7. Birth date of deceased Nov. 9 (Month) (Day) (Year)8. AGE: Years 1 Months 10 Days \_\_\_\_\_ (If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_)9. Birthplace (City, town, or county) \_\_\_\_\_ (State or foreign country) MO

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) \_\_\_\_\_ (b) Anthony Shapiro  
(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 Nov 21  
year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her 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? \_\_\_\_\_

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

S-35107