

FILED JUN 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21062**
Registrar's No. **5120**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or TOWN St. Louis)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lexington & N.Kingshighway		d. STREET ADDRESS (If rural, give location) 5125 Northland Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) Bartley c. (Last) Glover	4. DATE OF DEATH (Month) (Day) (Year) June 11, 1949						
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Dec. 30, 1895	9. AGE (In years last birthday) 53	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hour	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office worker		10b. KIND OF BUSINESS OR INDUSTRY Lincoln Engineering		11. BIRTHPLACE (State or foreign country) Mokane, Mo. G		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME Edward Glover	13b. MOTHER'S MAIDEN NAME Nancy Levine	14. NAME OF HUSBAND OR WIFE Rose Elizabeth Glover
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes	16. SOCIAL SECURITY NUMBER (If yes, give war or dates of service) World War I 494-10-1672	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Rose E. Glover-5125 Northland
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardiac Hypertrophy DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 952
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4343
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22. I hereby certify that I attended the deceased from **7**, 19___, to ___ , 19___, that I last saw the deceased alive on ___ , 19___, and that death occurred at **12:30 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Patrick E. Taylor Coroner	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 6-13-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/15/49	24c. NAME OF CEMETERY OR CREMATORY St. Peters	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. JUN 13 1949	REGISTRAR'S SIGNATURE J. B. Pasater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Drehmann-Harral - 1905 Union Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Coroner

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed..... *Albert R. Thompson*.....

Signed.....
Student Embalmer

Licensed Embalmer No. *4237*.....

P. O. Address *H. Jones*.....

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.