

FILED DEC 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40964

5551 State File No.

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. 32

1. PLACE OF DEATH a. COUNTY Howell		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howell	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN "R" Howell Twp. township)		c. LENGTH OF STAY (In this place) 12 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION Res. of Ed. Lindeman		c. CITY (If outside corporate limits, write RURAL and give township) West Plains,	
		d. STREET ADDRESS (If rural, give location) 420 Caldwell St.	

3. NAME OF DECEASED (Type or Print)	a. (First) FRED	b. (Middle) CHARLES	c. (Last) GLIEDT	4. DATE OF DEATH (Month) (Day) (Year) Dec. 10, 1949
----------------------------------------	------------------------	----------------------------	-------------------------	------------------------------------------------------------------

5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Sept. 4, 1882	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.
--------------------	-------------------------------	-----------------------------------------------------------------------	---------------------------------------	-------------------------------------------	-------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
-------------------------------------------------------------------------------------------------------------------	-----------------------------------	-----------------------------------------------------------------	----------------------------------------------

13a. FATHER'S NAME G. Gliedt	13b. MOTHER'S MAIDEN NAME Yohanna	14. NAME OF HUSBAND OR WIFE Clara Marie Gliedt
-------------------------------------	------------------------------------------	-------------------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Clara Gliedt, West Plains, Mo.	ADDRESS
---------------------------------------------------------------------------------------------------------------------	-------------------------------------	------------------------------------------------------------------------------	---------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4 222	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	----------------------------------	--------------------------------------------------------------------------

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)
------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------------

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?
------------------------------------------------------	--------------------------------------------------------------------------------------------------------	----------------------------

22. I hereby certify that I attended the deceased from **12/10**, 1948, to **12/10**, 1949, that I last saw the deceased alive on **11/20**, 1949, and that death occurred at **1:10P m.**, from the causes and on the date stated above.

23a. SIGNATURE E. A. Callahan M.D. (Degree or title)	23b. ADDRESS West Plains, Missouri	23c. DATE SIGNED
-------------------------------------------------------------	-------------------------------------------	------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 12/13/49	24c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.	24d. LOCATION (City, town, or county) (State) West Plains, Mo.
---------------------------------------------------------	---------------------------	---------------------------------------------------------	-----------------------------------------------------------------------

DATE REC'D BY LOCAL REG. 12-15-49	REGISTRAR'S SIGNATURE Beatrice Cook 379	25. FUNERAL DIRECTOR'S SIGNATURE Hal Thombert ADDRESS West Plains, Mo.
------------------------------------------	------------------------------------------------	--------------------------------------------------------------------------------------

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

011111 46
76

DEC 21 1949

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.

Student
Student Embalmer

Signed Hal Thompson

Licensed Embalmer No. 3408

P. O. Address West Plains

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.