

FILED MAY 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12363**

BIRTH NO. _____ REG. DIST. NO. **74** PRIMARY REG. DIST. NO. **5297** Registrar's No. **29**

0250
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY <i>Clinton</i>	b. CITY (If outside corporate limits, write RURAL and give town)	c. LENGTH OF STAY (in this place) <i>50 yrs</i>	a. STATE <i>Missouri</i> b. COUNTY <i>Ray</i>
b. CITY (If outside corporate limits, write RURAL and give town) <i>Rural Jackson</i>	c. LENGTH OF STAY (in this place) <i>50 yrs</i>	c. CITY (If outside corporate limits, write RURAL and give township) <i>Lawsan</i>	c. CITY (If outside corporate limits, write RURAL and give township) <i>0870</i>
d. FULL NAME OF HOSPITAL OR INSTITUTION	d. STREET ADDRESS (If rural, give location)		

3. NAME OF DECEASED			4. DATE OF DEATH		
a. (First) <i>JOHN</i>	b. (Middle) <i>THOMAS</i>	c. (Last) <i>GLASSCOCK</i>	(Month) <i>Mar</i>	(Day) <i>31</i>	(Year) <i>50</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>May 11 1895</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Lawsan Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>

13a. FATHER'S NAME <i>John Thomas Glasscock</i>	13b. MOTHER'S MAIDEN NAME <i>Fronicie McRackie</i>	14. NAME OF HUSBAND OR WIFE <i>Rosa Nelle Glasscock</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>World War I</i>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <i>Mrs Rosa Nelle Glasscock Lawsan</i>

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Accident, due to</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 minutes</i> <i>58 2/3</i> <i>38</i>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Farm implement (tractor) falling on body</i>		
	DUE TO (c) <i>Concussion of brain and hemorrhage</i>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <i>025</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <i>Accident</i>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Farm</i>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>Jackson Township, Clinton Mo</i>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>Mar 31 1950 AM</i>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Tractor overturned</i>

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, **that I last saw the deceased alive on** _____, 19____, **and that death occurred at** *9:30 AM*, from the causes and on the date stated above.

23a. SIGNATURE <i>R. D. Templeton</i> (Degree or title) <i>Coroner Clinton County Mo</i>	23b. ADDRESS <i>Cameron Mo</i>	23c. DATE SIGNED <i>3-31-50</i>
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>April 2 1950</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Union Cemetery</i>
		24d. LOCATION (City, town, or county) (State) <i>Ray County Missouri</i>

DATE REC'D BY LOCAL REG. <i>Apr. 19, 1950</i>	REGISTRAR'S SIGNATURE <i>Elizabeth Seearce</i>	441	25. FUNERAL DIRECTOR'S SIGNATURE <i>German Prichard</i>	ADDRESS <i>Lawsan Mo</i>
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MAY 23 1950



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 *Lowell K. Jarman*

Licensed Embalmer No. *4589*

P. O. Address *Excelsior Springs, Mo.*

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.