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THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

29993

FILED OCT 2 1950

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>834</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u> c. CITY (If outside corporate limits, write RURAL and give township) <u>1070</u> OR TOWN <u>Cabool</u> <u>1</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. LENGTH OF STAY (In this place) <u>2 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cabool</u> <u>1</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Burge Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>No street address</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Larry</u>		b. (Middle) <u>Dean</u>		c. (Last) <u>Glasscock</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 21 1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>		8. DATE OF BIRTH <u>June 25, 1949</u>		9. AGE (In years last birthday) <u>1</u> # UNDER 1 YEAR: Months <u>3</u> Days _____ # UNDER 1 HR. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cabool, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Claude Glasscock</u>		13b. MOTHER'S MAIDEN NAME <u>Frieda Gillenwert</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Claude Glasscock, Cabool, Mo.</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Ac Myocarditis - Cardiac dilatation & failure</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Ac Bronchitis bacterial</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>500X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 <u>Sept 19, 1950</u> to <u>Sept 20, 1950</u> , that I last saw the deceased alive on <u>Sept 20, 1950</u> , and that death occurred at <u>1:00A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>[Signature]</u>				23b. ADDRESS <u>m.d.o. 609 Cherry St.</u>		23c. DATE SIGNED <u>Sept 22, 1950</u>	
24a. BURIAL/CREMATION REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Sept 21, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		24d. LOCATION (City, town, or county) (State) <u>Cabool, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>9-26-50</u>		REGISTRAR'S SIGNATURE <u>W E Handley m.d.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Schmepp J.H. Springfield, Mo.</u>		ADDRESS <u>B.F.W.</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Bernard F. Wright

Signed _____

Student Embalmer

Licensed Embalmer No. *4293*

P. O. Address *Springfield, V*

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.