

FILED DEC 9 1952

STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. _____ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 5374 Registrar's No. 47

1320
1

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

1. PLACE OF DEATH a. COUNTY DeKalb		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Life b. COUNTY DeKalb	
b. CITY (If outside corporate limits, write RURAL and give town) Maysville R, Colfax		c. CITY (If outside corporate limits, write RURAL and give township) OR Maysville, Rural, Colfax <u>0320</u>	
c. LENGTH OF STAY (In this place) 50 yrs		d. STREET ADDRESS (If rural, give location) 4 Miles south of Maysville	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) JOHN	b. (Middle) Albert	c. (Last) Glenn	(Month) Nov	(Day) 11	(Year) 52

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12-13 XXXXXX 1873	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR (Month) 10 (Day) 29	IF UNDER 24 HRS. (Hour) (Min.)
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Mo,	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Thomas Glenn	13b. MOTHER'S MAIDEN NAME Martha Keath	14. NAME OF HUSBAND OR WIFE Bertha Glenn
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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. XXXX	17. INFORMANT'S SIGNATURE OR NAME Clarence Glenn Osborne	ADDRESS Mo
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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, ashenia, 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) Hypertensive Cardiovascular disease		3 years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congestive Heart failure		2 years
DUE TO (c) arteriosclerosis (General)		?	
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 type="checkbox"/> NO <input checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from April, 1950, to June, 1952, that I last saw the deceased alive on Nov, 1952, and that death occurred at 9 A. m., from the causes and on the date stated above.

23a. SIGNATURE James F. Sweger (Degree or title) MD	23b. ADDRESS Maysville Mo	23c. DATE SIGNED 11-28-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-14-52	24c. NAME OF CEMETERY OR CREMATORY Oak Lawn	24d. LOCATION (City, town, or county) (State) Maysville Mo
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DATE REC'D BY LOCAL REG. 12-6-52	REGISTRAR'S SIGNATURE James F. Sweger	25. FUNERAL DIRECTOR'S SIGNATURE John Brown	ADDRESS Maysville Mo
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(Licensed Embalmer's Statement on Reverse Side)

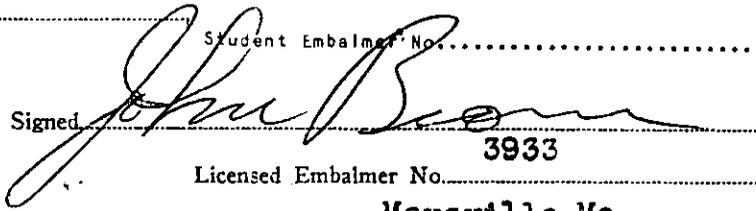
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....



3933

Licensed Embalmer No.....

P. O. Address Maysville Mo

Signed.....
Student Embalmer

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.