

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1328**

No. 300
10.48

BIRTH NO. **FILED FEB 11 1954** REG. DIST. NO. **147** PRIMARY REG. DIST. NO. **1002** Registrar's No. **344**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY OR TOWN Kansas City	c. LENGTH OF STAY (in this place) 50 yrs.	c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital #2		e. STREET ADDRESS (If rural, give location) 1716 Prospect Avenue	3288

3. NAME OF DECEASED (Type or Print)	a. (First) Gracie	b. (Middle)	c. (Last) Glenn	4. DATE OF DEATH (Month) 1 (Day) 19 (Year) 1954
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5. SEX 3 Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH Sept. 16, 1886	9. AGE (In years last birthday) 67	10. CITIZENSHIP USA
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Addison, Kansas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Ida Talbert	14. NAME OF HUSBAND OR WIFE Albert 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. None	17. INFORMANT'S SIGNATURE OR NAME Queenie Cain	ADDRESS 1615 Agnes
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
19. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Lympho granuloma, inguinal.	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) (Min.)	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 12-29-53, 19 , to 1-19-54, 19 , that I last saw the deceased alive on 1-19-54, 19 , and that death occurred at 3:30 p m., from the causes and on the date stated above.

23a. SIGNATURE E. Frank Ellis MD	(Degree or title) MD	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 1-21-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/23/54	24c. NAME OF CEMETERY OR CREMATORY Highland Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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DATE REC'D BY LOCAL REG. 1-22-54	REGISTRAR'S SIGNATURE Geraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Watkinson Bros. 18th & Benton	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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..

Student.....
Signature of Student Embalmer

Signed..... *Bruce K. Robinson*

Licensed Embalmer No. *45*

P. O. Address *18th & B...*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.