

35522

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

8921

Registrar's No. ....

1003

REG. DIST. NO. 318 PRIMARY REG. DIST. NO.

BIRTH NO. ....

FILED OCT 26 1954

|   |                               |  |  |   |  |
|---|-------------------------------|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                               |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Illinois</u> , b. COUNTY <u>Massac</u> |   |  |
| b. CITY OR TOWN <u>ST. LOUIS, MO.</u>   |                               | c. LENGTH OF STAY (in this place)  | c. CITY OR TOWN <u>Metropolis</u>  |   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>  |                               |  | e. STREET ADDRESS (If rural, give location) <u>812<sup>0</sup> 8</u>   |   |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>Glen</u> b. (Middle) <u>NMN</u> c. (Last) <u>Jameson</u>  |                               |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>Sept. 29 1954</u>   |   |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>                                  | 8. DATE OF BIRTH<br><u>June 20, 1902</u>   | 9. AGE (In years last birthday) <u>52</u>   | 10. <input type="checkbox"/> UNDER 1 YEAR<br><input type="checkbox"/> 1 YEAR<br><input type="checkbox"/> 5 YEARS<br><input type="checkbox"/> OVER 5 YRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Self Employed</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (City and State or Foreign Country)<br><u>? Tenn.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |
| 13a. FATHER'S NAME<br><u>Jess Jameson</u>   |                               | 13b. MOTHER'S MAIDEN NAME<br><u>Unk.</u>   |  | 14. NAME OF HUSBAND OR WIFE<br><u>Ollie Jameson</u>                                 |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)<br><u>No.</u>   |                               | 16. SOCIAL SECURITY NO.<br><u>Nil</u>  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>Wm. Jameson, Metropolis, Ill.</u>  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)   |                               |  | MEDICAL CERTIFICATION  |   |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Brain Tumor (non-metastatic)</u>  |                               |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 mo.</u>   |   |  |
| *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.   |                               |  | II. OTHER SIGNIFICANT CONDITIONS<br>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?<br>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)<br><u>223X</u>   |   |  |
| 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 <u>Sept. 19, 1954</u> , to <u>Sept. 29, 1954</u> , that I last saw the deceased alive on <u>Sept. 29, 1954</u> , and that death occurred at <u>7:10P m.</u> , from the causes and on the date stated above. |                               |  |  |   |  |
| 23a. SIGNATURE<br><u>C. J. McMillin, M.D.</u> (Degree or title)   |                               |  | 23b. ADDRESS<br><u>BARNES HOSPITAL</u>   |   | 23c. DATE SIGNED<br><u>9/29/54</u>   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)   |                               | 24b. DATE<br><u>9-30-54</u>  | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Local</u>   | 24d. LOCATION (City, town, or county) (State)<br><u>Metropolis, Ill.</u>            |  |
| DATE REC'D BY LOCAL REG.<br><u>OCT 1 1954</u>   |                               | REGISTRAR'S SIGNATURE<br><u>J. Carl Smith MD</u>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>Albert H. Hoppe 4700 Washington.</u> |  |

(Licensed Embalmer's Statement on Reverse Side)

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

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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 *Elmer R. Radwael*.....

Licensed Embalmer No. *407*.....

P. O. Address *St. Louis*.....

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.