

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1017**

FILED JAN 23 1956

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **50**

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

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY GREENE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD		c. LENGTH OF STAY (In this place) 22 DAYS	c. CITY OR TOWN SPRINGFIELD
d. FULL NAME OF HOSPITAL OR INSTITUTION BURGE HOSPITAL		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) C. c. (Last) GLENN		4. DATE OF DEATH (Month) (Day) (Year) JAN. 13, 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 27 JULY 1869
9. AGE (In years last birthday) 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	11. BIRTHPLACE (City and State or Foreign Country) MISSOURI
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME JOHN GLENN		13b. MOTHER'S MAIDEN NAME CATHERINE JENNINGS	14. NAME OF HUSBAND OR WIFE PEARL GLENN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS HOSPITAL RECORDS	
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* (a) Carcinoma of stomach ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 151X	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 Sept , 19 55 , to Jan 13, 1956 , that I last saw the deceased alive on Jan 13 , 19 56 , and that death occurred at 2:20 P. m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) D. Dean Cunningham M.D.		23b. ADDRESS 1715 BOONVILLE SPRINGFIELD, MO.	23c. DATE SIGNED 1-14-56
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1-15-56	24c. NAME OF CEMETERY OR CREMATORY BELLYVIEW	24d. LOCATION (City, town, or county) (State) GREENE COUNTY, MO.
DATE REC'D BY LOCAL REG 1-16-56	REGISTRAR'S SIGNATURE (Edith Williamson)	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jurkingner & Co. Spfld. Mo.	

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..... *Ozle Slone Jr*
Licensed Embalmer No. *4126*

P. O. Address. *Springfield*

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.