

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12359

FILED APR 17 1957

STATE FILE NUMBER

Registration District No. 389

Primary Registration District No. 5761

Registrar's No. 7

Health & Welfare  
Public Health Service

S. 300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>New Bloomfield</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>New Bloomfield</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cedar TWP</u> Length of stay in lb <u>7 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>Reside on Farm</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MARIAH</u> Last <u>GLENNEN</u>			4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>57</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 2 - 1893</u>
9. AGE (In years last birthday) <u>63</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u>4</u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11. BIRTHPLACE (City and state or country) <u>Callaway Co Mo</u>
13. FATHER'S NAME <u>Monroe Bryant</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
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></u>	17. INFORMANT Address <u>Mrs B.M. Greenway New Bloomfield</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4500</u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Jan 1955</u> to <u>April 6-57</u> and last saw her <u>alive</u> on <u>April 2-57</u> Death occurred at <u>7 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>E. M. Kusk MD</u>		22b. ADDRESS <u>New Bloomfield Mo</u>	
22c. DATE SIGNED <u>4/7 1957</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Apr 8-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Bloomfield</u>	23d. LOCATION (City, town, or county) (State) <u>New Bloomfield MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>Hoet-Clayton New Bloomfield Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Apr 7-1957</u>	26. REGISTRAR'S SIGNATURE <u>LeRoy Clayton</u>

(Licensed Embalmer's Statement on Reverse Side)

39-0

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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 .....

*LeRoy Doyon*

Licensed Embalmer No. 4417

P. O. Address *New Bloomf*

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.