

health, Welfare public service  
 300 1-56  
 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  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms write as listed. All

FILED FEB 14 1958

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

2951

Registration District No. **318** Primary Registration District No. **1003** STATE FILE NUMBER **1124**  
 Registrar's No. **1124**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>#15 Beverly Pl.</b>			Length of stay in lb	d. STREET ADDRESS <b>15 Beverly Pl.</b>			Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>Gregory</b> Last <b>Glacken</b>				4. DATE OF DEATH Month <b>1</b> Day <b>29</b> Year <b>58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>August 11, 1898</b>	9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>29</b> Hours <b>59</b> Min.	IF UNDER 24 HRS. Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mail Order Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Glacken</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Harnnett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>489 03 6071</b>		17. INFORMANT Address <b>Justin Glacken 15 Beverly Pl.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) <b>Myocardial Aneurysm</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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.) <b>420.1</b>				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION			COUNTY		STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>4:30 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>James M Kelly</b>				22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>1-29-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>1-31-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>J. W. Clark F. H. 1125 Hodiamont Ave.</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 30 '58</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	

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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. *Alfred J. Bader*  
Licensed Embalmer No. *26*  
P. O. Address. *11257th*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.