

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028273  
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 890

FILED AUG 25 1958

S. 300  
1-57

All diseases in Part I must be causally related.  
 Secondary conditions, where possible, must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Joseph</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>611 N. 11th Street</b>			Length of stay in 1b <b>11 years.</b>	8. STREET ADDRESS (If outside, give location) <b>1419 Felix Street</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Josephine</b> Last <b>Glaskin</b>				4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>1958.</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 9, 1876</b>		9. AGE (In years last birthday) <b>82</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (City and state or country) <b>Rockport, Missouri.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>William Crawford Smith</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Angeline Jeffrey</b>		14. NAME OF HUSBAND OR WIFE <b>David Glaskin</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>none</b>	17. INFORMANT <b>J. Leonard Smith</b>		Address <b>St. Joseph, Mo.</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>Arteriosclerotic Heart Disease with Aortic Stenosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis general</b>						Unknown	
DUE TO (c) <b>4200</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c) <b>Cerebral arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>	
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 <b>2:15 P</b> Month, Day, Year							
20d. INJURY OCCURRED WHILE AT <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 <b>St. Joseph, Missouri</b>		COUNTY <b>Buchanan</b> STATE <b>Missouri</b>	
21. I attended the deceased from <b>3-22-49</b> to <b>8-15-58</b> and last saw <b>her</b> alive on <b>8-6-58</b> Death occurred at <b>2:15 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated. <b>207 Phy. and Surg.</b>							
22a. SIGNATURE, <b>N C Senne md</b> (Degree or title)				22b. ADDRESS <b>Saint Joseph, Missouri</b>		22c. DATE SIGNED <b>8-16-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug. 18, 1958.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri.</b>		
24. FUNERAL DIRECTOR <b>W. C. Senne</b> ADDRESS <b>St. Joseph, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>Aug 18 1958</b>		26. REGISTRAR'S SIGNATURE <b>Wm. Clark Gendell</b>		

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 *Albert C. Jernigan*  
.....  
Licensed Embalmer No. *4079 3258*

P. O. Address *St. Joseph, Mo.*.....

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.