

Health,
& Welfare
Public
Service

X

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032111

STATE FILE NUMBER

FILED OCT 15 1958

Registration District No. 75 Primary Registration District No. 5301-3015 Registrar's No. 115

5030
300
1-57

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>OHIO</u> b. COUNTY <u>Madison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Shoal Creek</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Youngstown</u> <u>8346</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3 MI. S. CAMERON, Mo.</u> Length of stay in 1b <u>Tourist</u>		d. STREET ADDRESS (If outside, give location) <u>1999 Meridian Rd.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First <u>Michael</u> Middle <u>(none)</u> Last <u>Gluska</u>			4. DATE OF DEATH Month <u>10</u> Day <u>5</u> Year <u>58</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-31-38</u>
9. AGE (In years last birthday) <u>20</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Discharged From Army</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Youngstown, OHIO</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>
14. NAME OF HUSBAND OR WIFE <u>None</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 6/22/55 - 6/27/58</u>	16. SOCIAL SECURITY NO. <u>289-32-6806</u>
17. INFORMANT <u>Armed Services Discharge Papers</u>		Address	
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>Crushing Injury to head</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>Automobile Accident</u>		
20c. TIME OF INJURY Hour <u>6</u> Month, Day, Year <u>10 5 58</u> p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway 69</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Clinton Mo.</u>	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <u>6:05</u> <u>A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Paul Warren, D.O., Cor.</u>		22b. ADDRESS <u>Lathrop, Mo.</u>	22c. DATE SIGNED <u>10-5-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>10-5-58</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <u>Youngstown, OHIO</u>
24. FUNERAL DIRECTOR <u>Poland Cameron Mo</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Oct 5-58</u>	26. REGISTRAR'S SIGNATURE <u>Francis D. Crawford</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 Robert F Polow

Licensed Embalmer No. 4777

P. O. Address Cameron

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.