

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002106

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 22

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hannibal</u> <u>0640</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>Levering Hosp.</u>		Length of stay in lb <u>Life</u>	d. STREET ADDRESS (If outside, give location) <u>309 Magnolia</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Lucy</u> Last <u>Glascoek</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>20</u> Year <u>1959</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 3. 1875</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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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>None</u>	11. BIRTHPLACE (City and state or country) <u>Perry, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Marshall Ford</u>	13b. MOTHER'S MAIDEN NAME <u>Eura Faunce</u>	14. NAME OF HUSBAND OR WIFE <u>Benjamin F. Glascock</u>
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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 <u>Mrs. Palmeta Faunce</u> Address <u>309 Magnolia</u>
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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>Bronchial pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>bilateral infection both parotid glands</u>	
	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"/> <u>2</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.)
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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 <u>Hannibal, Mo.</u>	COUNTY _____ STATE _____
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21. I attended the deceased from <u>12/19/58</u> to <u>1/20/59</u> and last saw her/him alive on <u>1/20/59</u> Death occurred at <u>8:45 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>E. L. Murphy M.D.</u>	22b. ADDRESS <u>100 N. 6th, Hannibal, Mo.</u>	22c. DATE SIGNED <u>1/27/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 27. 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Clivet</u>	23d. LOCATION (City, town, or county) <u>Hannibal, Missouri</u>	(State) _____
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24. FUNERAL DIRECTOR <u>Jack Schwarz</u> ADDRESS <u>Hannibal, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-27-1959</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke by H. L. Fisher</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
-57

All diseases in Part I must be causally related.

RECEIVED FEB 3 1959
MARION CO. HEALTH DEPT.,
DATE FILED FEB 3 1959

3091 9 331

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 Jack Schwart

Licensed Embalmer No. 4900

P. O. Address Hannibal, 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.