

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017024

STATE FILE NUMBER

MAY 18 1959

Registration District No. 55 Primary Registration District No. 5790 Registrar's No. 36

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carrollton Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Carrollton</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTIONS <u>3 mi N.W. Carrollton</u>		Length of stay in lb <u>0/70</u>	d. STREET ADDRESS (If outside, give location) <u>0 R.F.D. 2#</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Burr Glaze</u>			4. DATE OF DEATH Month Day Year <u>May 8, 1959</u>		
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>Aug. 10, 1915</u>	9. AGE (In years last birthday) <u>43</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Leslie Twp Carroll Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Ben Glaze</u>	13b. MOTHER'S MAIDEN NAME <u>Mattie Mann</u>	14. NAME OF HUSBAND OR WIFE <u>Irene Glaze</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>495-42-5524</u>	17. INFORMANT <u>Mrs. E.B. Glaze</u>	Address <u>Carrollton, Mo.</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>Crushed chest due to tractor falling into ditch</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instantly</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>9/21</u>	
	DUE TO (c) <u>3</u>	
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>Tractor into ditch on top of worker fell</u>
20c. TIME OF INJURY Hour Month, Day, Year <u>9:15 a.m. May 8/59</u>	

20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>field</u>	20f. CITY, TOWN, OR LOCATION <u>Carrollton, Mo.</u>	COUNTY <u>Carroll</u>	STATE <u>Mo.</u>
21. I attended the deceased from death occurred at <u>9:15</u> on <u>5/8/59</u> from <u>May 8/59</u> to <u>May 8/59</u> and last saw him alive on <u>May 7/59</u> m on the day stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>B. Hamilton</u>	(Regist. or Info.)	22b. ADDRESS <u>Carrollton, Missouri</u>	22c. DATE SIGNED <u>5/8/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5/10/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>N.W. Bogard, Mo.</u>
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24. FUNERAL DIRECTOR <u>Marshall Funeral Home</u>	ADDRESS <u>Carrollton</u>	25. DATE RECD. BY LOCAL REG. <u>5/12/59</u>	26. REGISTRAR'S SIGNATURE <u>Miss Herbert Calvert</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 10. No symptoms with be listed. All diseases in Part I must be causally related.

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 Samuel M. Rice, Student Embalmer No. 577 working under my personal supervision.

Student Samuel M. Rice
Signature of Student Embalmer

Signed [Signature]

Licensed Embalmer No. 4469
P. O. Address Canalton 7

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.