

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024760

FILED VS JUL 27 1959

Registration District No. 728 Primary Registration District No. 2000 Registrar's No. 774

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Length of stay in 1b 6 weeks	c. CITY OR TOWN Rogersville		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route 3		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DORA Middle E. Last GLAUBITZ			4. DATE OF DEATH Month July Day 19 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Jan 23, 1877	9. AGE (last birthday) 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Turner, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Winfield S. Dillard		13b. MOTHER'S MAIDEN NAME Josie Walterson		14. NAME OF HUSBAND OR WIFE Lawrence A. Glaubitz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Lawrence A. Glaubitz, Rogersville, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Generalized arteriosclerosis and arterio-sclerotic heart disease. occurred about 2 hr after			
		DUE TO (c) Electroshock therapy			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic brain syndrome, psychotic type, with marked depressive features				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)			
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year				
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 May 21, 1959 to July 18, 1959 and last saw her/him alive on July 18, 1959 Death occurred at 8:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>[Signature]</i>		(Degree or title)	22b. ADDRESS 7636 S. Glen-Tone Springfield Mo		22c. DATE SIGNED July 20 1959
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 21, 1959	23c. NAME OF CEMETERY OR CREMATORY Eastlawn Cemetery	23d. LOCATION (City, town, or county) Springfield, Mo.		
24. FUNERAL DIRECTOR Jewell E. Windb		ADDRESS B.W. Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 7-21-59	26. REGISTRAR'S SIGNATURE Effie G. Melton	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bernard F. Wrigg

Licensed Embalmer No. 429

P. O. Address. Spring

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