

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038487

FILED VS OCT 22 1959 317

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2726

INDEXED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch, Missouri</u>	Length of stay in 1b <u>6 days</u>	c. CITY OR TOWN <u>St. Louis</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>Robt. Koch Hospital</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2647 Accomac</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>M.</u> Last <u>Glenn</u>			4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>9-21-95</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (City and state or country) <u>Desoto, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>

13a. FATHER'S NAME <u>Patrick Glenn</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Flynn</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 WWI</u>		16. SOCIAL SECURITY NO. <u>494-10-8464</u>		17. INFORMANT <u>Alice Glenn 2747 Lafayette Ave. Koch Hosp. Records Koch Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u>
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>			
DUE TO (b) <u>Bronchoscopy</u>			
DUE TO (c) <u>Cocaine Reaction in debilitated pt.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Far Advanced Pulmonary Tuberculosis</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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.) <u>002x</u>	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>	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.) <u> </u>	20f. CITY, TOWN, OR LOCATION <u> </u> COUNTY <u> </u> STATE <u> </u>

21. I attended the deceased from 10-14-59 to 10-15-59 and last saw him alive on 10-14-59 10^{PM}. Death occurred at 1:33 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>William J. Goltzman MD.</u>		22b. ADDRESS <u>1323 McCutcheon St. St. Louis Mo</u>		22c. DATE SIGNED <u>10-15-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10/16/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	23d. LOCATION (City, town, or county) (State) <u>DeSoto, Missouri</u>	

24. FUNERAL DIRECTOR <u>E.J. Schnur</u> ADDRESS <u>3125 Lafayette Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>10-15-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M. Smith

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 Thomas R. Jenuve

Licensed Embalmer No. 3793

P. O. Address 3125 Lafayette

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.