URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-028351

FILED VS AUG 4 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7275

STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 2845 Russell Blvd.
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2845 Russell Blvd.
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: John Middle: H. Last: Glover

4. DATE OF DEATH: Month Day Year: 7/20/60

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 9/3/86

9. AGE (last birthday): 73 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elevator Operator

10b. KIND OF BUSINESS OR INDUSTRY: Intern. Shoe Co.

11. BIRTHPLACE (City and state or country): Wis. Lemars

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: John H. Glover

13b. MOTHER'S MAIDEN NAME: Mary Thomas

14. NAME OF HUSBAND OR WIFE: Agnes B. Shryock Glover

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. 1

16. SOCIAL SECURITY NO.: 488-30-5082

17. INFORMANT: Agnes Glover Address: 2845 Russell Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Decompensation
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 434.4
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Partial Hemiplegia

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 1957, to 7-20-60 and last saw her/him alive on 7-18-60

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: John O'Hover (Degree or title) D.O.

22b. ADDRESS: 1652 California

22c. DATE SIGNED: 7-21-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 7/22/60

23c. NAME OF CEMETERY OR CREMATORY: Mt. Lebanon

23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

24. FUNERAL DIRECTOR: E.J. Schnur ADDRESS: 3125 Lafayette Ave.

25. DATE RECD. BY LOCAL REG.: JUL 21 1960

26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed Thomas R. Fenw

Signature of Student Embalmer

Licensed Embalmer No. 3793

P. O. Address 3125 Lafay

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