

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

371-61-012674 STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 371

FILED APR 17 1961

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 50yrs	c. CITY OR TOWN St. Joseph, Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7113 King Hill Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Joseph Russell Gloschen			4. DATE OF DEATH Month Day Year April 7, 1961		
5. SEX Male	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 May 24, 1910	9. AGE (last birthday) 50	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner		10b. KIND OF BUSINESS OR INDUSTRY Tavern	11. BIRTHPLACE (City and state or country) Clarinda Iowa		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Olen A Glosehn		13b. MOTHER'S MAIDEN NAME Ora Tea Phillips		14. NAME OF HUSBAND OR WIFE Ila Gloschen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO.		17. INFORMANT Larry Glosehn St. Joseph, Mo Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Rupture aneurysm circle of Willis</i>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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	
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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 St. Joseph, Mo	COUNTY Mo	STATE
21. I attended the deceased from <i>1940</i> to <i>4/7/61</i> and last saw him alive on <i>4-7-61</i> Death occurred at <i>5 P.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <i>Irina Rosenthal M.D.</i> (Degree or title)	22b. ADDRESS <i>St Joseph Mo</i>	22c. DATE SIGNED <i>4-10-61</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>4/11/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cemetery</i>	23d. LOCATION (City, town, or county) <i>St. Joseph, Mo</i> (State)

24. FUNERAL DIRECTOR <i>John E. Krupp</i> ADDRESS <i>St. Joseph, Mo</i>	25. DATE RECD. BY LOCAL REG. <i>April 14, 1961</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Sandell</i>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

CERTIFICATION

BY AFFIDAVIT OF
Irina Rosenthal, M.D.

ITEM NO. SHOULD READ

APR 18 1961

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~~ _____

Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

John E. Repp

Licensed Embalmer No. 3986

P. O. Address St. Joseph

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.