

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-045260

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 3116

FILED NOV 19 1962

VS 300	DATE AMENDED
Rev. 4/59	
<u>4000</u>	
2 <u>203</u>	
3	
4 <u>0</u>	
5 <u>1</u>	
6	
7 <u>1</u>	
8 <u>2</u>	
<u>9442X</u>	
10	
11	
12 <u>86-0</u>	
13	
<u>88</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY -	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Manchester		Length of stay in lb 3 mos.	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Manchester Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6968 Hancock Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frank Middle J. Last Glasner			4. DATE OF DEATH Month OCT. Day 26 Year 1962
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 9-20-1876
9. AGE (last birthday) 86		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) Supt. of Const. Work		10b. KIND OF BUSINESS OR INDUSTRY Callahan Const. Co.	11. BIRTHPLACE (City and state or country) Zoine, N.Y.
12. CITIZEN OF WHAT COUNTRY U.S.		13a. FATHER'S NAME Pete Glasner	
13b. MOTHER'S MAIDEN NAME Clements Bondya		14. NAME OF HUSBAND OR WIFE Emma Glasner	
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. none	
17. INFORMANT Mrs. Muriel Lockwood, 6968 Hancock		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) CARDIO-VASCULAR RENAL DISEASE DUE TO (b) SENILITY DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			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) NONE			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.)	
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 JULY 4, 1962 to _____ and last saw him alive on OCT. 26, 1962 Death occurred at 7:14 P. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE B. R. Loving, M.D. (Degree or title)		22b. ADDRESS BALLWIN, MO.	
22c. DATE SIGNED 10-27-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10-29-62	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR Hoffmeister Colonial, 6464 Chippewa		25. DATE RECD. BY LOCAL REG. 10-27-62	26. REGISTRAR'S SIGNATURE John C. Mumphy, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

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

John J. Denney

Licensed Embalmer No. 4194

P. O. Address St. Louis, Mo.

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.

RECEIVED

10-1-31