

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-011374

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 137 Primary Registration District No. 4218 Registrar's No. 90

FILED MAR 25 1963

| | | | |
|---|------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Henry | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE California COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Windsor | | Length of stay in lb 3 years | c. CITY OR TOWN San Jose Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Resthaven, Inc. | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 408 E. San Salvador Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last ADAM WALDEMAR GLASS | | 4. DATE OF DEATH Month Day Year March 14, 1963 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 4-3-1884 |
| 9. AGE (last birthday) 78 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman-Boat Captain | | 10b. KIND OF BUSINESS OR INDUSTRY Sea transportation freight & passengers | |
| 11. BIRTHPLACE (City and state or country) Skellefte, Sweden | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Adam Glass | | 13b. MOTHER'S MAIDEN NAME Augusta Wickstorm | |
| 14. NAME OF HUSBAND OR WIFE Anna W. Field | | 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. 561-05-2436 | | 17. INFORMANT Address Robert Field, Windsor, 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) Circulatory Collapse DUE TO (b) Influenza DUE TO (c) Virus Infection PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Paralysis left side + Hypertension | | | INTERVAL BETWEEN ONSET AND DEATH 2 days 7 days 7 days |
| 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.) | | PART III. If deceased was female, was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 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 March 8, 1963 to March 14, 1963 and last saw him alive on March 13, 1963 Death occurred at 4:05 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) William J. Smith MD | | 22b. ADDRESS | |
| 22c. DATE SIGNED | | 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) cremation | 23b. DATE 3-18-63 | 23c. NAME OF CEMETERY OR CREMATORY D.W. Newcomers | |
| 24. FUNERAL DIRECTOR ADDRESS Ellis M. Huston, Windsor, Mo. | | 25. DATE RECD. BY LOCAL REG. 3-18-1963 | |
| 26. REGISTRAR'S SIGNATURE Mildred Biguno | | | |

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

12-1-1963

12-1-1963

12-1-1963

12-1-1963

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STATEMENT BY LICENSED EMBALMER

12-1-1963

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 Wm. H. Hinton

Licensed Embalmer No. 3391

P. O. Address Windsor, 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.