

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2498

FILED FEB 4 1946

Registration District No. 80

Primary Registration District No. 5307-4142

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Cole
(b) City or town Russellville, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Leonard W. Glover

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lizzie Glover 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 17 1874
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>11</u>	<u>2</u>	_____ hr. _____ min.

9. Birthplace Russellville, Mo (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name James Glover
13. Birthplace Cole County (City, town, or county) (State or foreign country)
14. Maiden name Sarah Amos
15. Birthplace Cole County (City, town, or county) (State or foreign country)

16. (a) Informant Dorothy Chambers
(b) Address Jefferson City, Mo

17. (a) Burial (b) Date thereof 1-21-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Campbell Cemetery

18. (a) Signature of funeral director H. Schubert
(b) Address Russellville Mo.

19. (a) Jan 21-1946 (b) Miss Minnie Hittmeyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole
(c) City or town Russellville
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 19
year 1946 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from Nov. 5 to Jan 12, 1946
that I last saw him alive on Jan 12, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia Duration _____Due to Life as chronic poisoning

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature E. M. Elshar (M. D. or other) D.O.Address Russellville Mo. Date signed 1/21/46ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 2-2-46

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No. 2829

P. O. Address Russellville

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 this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Feb

Registration District No.

60

Primary Registration District No.

4143

Registrar's No.

2

1. PLACE OF DEATH:

(a) County Cal
(b) City or town Russellville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME

Leonard W. Glover

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive

7. Birth date of deceased Feb 17 (Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 17 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan year 1946 hour minute M.

21. I hereby certify that I attended the deceased from 1946 to 1946,
that I last saw him alive on Jan 19, 1946,
and that death occurred on the date and hour stated above.
Immediate cause of death

Due to

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) suicide

(b) Date of occurrence Jan 19, 1946

(c) Where did injury occur? Col (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

In home on farm

While at work? (Specify type of place) (e) Means of injury Train

23. Signature E. M. Elmhurst (M. D. or other) D.O.

Address Russellville Date signed 2/14/46

488 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
(REGISTERED)

PHYSICIAN

Underline the cause to which death should be charged statistically.

2498