MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

File No. 19441

Registered No. 458

1. PLACE OF DEATH

County: Greene

Registration District No. 318

Township: Springfield

Primary Registration District No. 2001

City: Springfield Mo (No. 1603 W Chestnut St., Ward)

2. FULL NAME: Glen W. Gallion

(a) Residence. No. 1603 W Chestnut St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Child

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF: School Child.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Feb 4, 1920

7. AGE: Years 13 | Months | Days 7 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.:

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.:

10. Date deceased last worked at this occupation (month and year): School

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo

FATHER

13. NAME: Walter Gallion

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo

MOTHER

15. MAIDEN NAME: Ethel Morton

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo

17. INFORMANT: Walter Gallion
(ADDRESS) 1603 W Chestnut

18. BURIAL, CREMATION, OR REMOVAL: Maple Park, June 13, 1933

19. UNDERTAKER: Floyd W Fox
(ADDRESS) 1639 W Walnut

20. FILED 6-13, 1933

Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 11, 1933

22. I HEREBY CERTIFY, That I attended deceased from May 20, 1933, to June 10, 1933

I last saw him alive on June 10, 1933. Death is said to have occurred on the date stated above, at 9 AM m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Typhoid Fever	May 20

Other contributory causes of importance:

Malnutrition, Pneumonia, and Tonsilitis

Name of operation: None Date of:

What test confirmed diagnosis? Clinical. Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) M.D.

(Address) 814 N Campbell

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD