

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.

REC'D MAY 19 1939

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

15016
Do not use this space.

1. PLACE OF DEATH

(a) County Howell Registration District No. 384

(b) Township 1 Primary Registration District No. 4227 Registered No. _____

(c) City West Plains, (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred 80 yrs. 5 mos. 0 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME SAMUEL J. GALLOWAY

(a) Residence, No. 702 Cass Ave. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Vesta Clack Galloway

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 2, 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

80 5 0

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Farmer

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

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

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Plains, Mo.

FATHER

13. NAME W.R. Galloway

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

MOTHER

15. MAIDEN NAME Rhoda Stinecipher

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

17. INFORMANT (ADDRESS) Paul Galloway West Plains, Mo.

18. BURIAL, CREMATION, OR REMOVAL Oak Lawn Cem.
PLACE West Plains, Mo. DATE April 4, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hal Thornburgh West Plains, Mo.

20. FILED 4-4-39 Vida W SIMONS
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 2, 1939

22. I HEREBY CERTIFY, That I attended deceased from 1934 to April 2, 1939

I last saw h. ib alive on April 2, 1939 Death is said to have occurred on the date stated above, at 6: a m.

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

Chronic Myocarditis

Date of onset _____

Other contributory causes of importance: 920

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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? no
If so, specify _____
(Signed) W. H. Baggett, M. D.
344 (Address) West Plains, Mo.

AUG 3 1947

SEP 6 1955

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,

Hal Thornburgh, or by

Registered Apprentice No., working under my personal supervision.

Signed..... Hal Thornburgh

Licensed Embalmer No. 3408

P. O. Address West Plains, 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 this body is not embalmed, above space should be left blank.