DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9726

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 1160

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution / (Specify whether
In this community: 30 Yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Kansas City Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 1412 Central
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Louis GALLET. 430

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Nora Gallet.

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased: Sept. (Month) 16th (Day) 1870 (Year)

8. AGE: Years 69 | Months 5 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace: St. Paul (City, town, or county) Kansas (State or foreign country)

10. Usual occupation: Chef.

11. Industry or business: U. S. Gov. Barge.

MOTHER / FATHER

12. Name: Unknown

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

14. Maiden name: Unknown

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

16. (a) Informant's own signature: Walter Gallet.

(b) Address: 1412 Central.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/14/40 (Month) (Day) (Year)

(c) Place: burial or cremation: Calvary Cemetery

18. (a) Signature of funeral director: Hellody-McGilley.

(b) Address: K. C. Mo.

19. (a) 3-14-40 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12th year 1940 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan 10-40, 19__, to May 12, 1940, that I last saw him alive on March 11, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebrovascular Hemorrhage

Due to: Pneumonia, lobar

Due to: Uremia

Other conditions: No
(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy: No

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: [illegible] (M. D. or other)

Address: 927 Argyle Bldg. Date signed: 3/14/40

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-1-39 I X19511

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

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.

DR. GIST
3950 Victor.

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. 2999

P. O. Address.....

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.