

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23535
State File No. _____
Registrar's No. **5989**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **City Hospital, #1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **14 Days**
(Specify whether
In this community **50 YEARS**
years, months or days)

3. (a) PRINT FULL NAME **Jacob Gallop** **410**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **SINGLE**

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

7. Birth date of deceased **UNK. AB. 1888**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
AB. 52 hr. min.

9. Birthplace **KAMENETZ PODOLSK, RUSSIA 7**
(City, town, or county) (State or foreign country)

10. Usual occupation **SALESMAN**

11. Industry or business _____

MOTHER FATHER { 12. Name **ISRAEL GALLOP**
13. Birthplace **RUSSIA 7**
(City, town, or county) (State or foreign country)
14. Maiden name **ANNIE (UNK)**
15. Birthplace **10 9**
(City, town, or county) (State or foreign country)

16. (a) Informant **PHIL GALLOP**
(b) Address **7275a DARTMOUTH**

17. (a) **BURIAL** (b) Date thereof **7/17/1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CHESED SHEL EMEH**

18. (a) Signature of funeral director **H. B. BERGER**

(b) Address **4715 McPHERSON**

19. (a) **JUL 17 1940** (b) **J. F. Brudeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County _____
(c) City or town **ST. LOUIS** **21**
(If outside city or town limits, write "RURAL")
(d) Street No. **19TH + O'FALLON**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **50** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **16**,
year **1940** hour **12:02** minute **A. M.**

21. I hereby certify that I attended the deceased from **July**
2, 19 **40** to **July 16**, 19 **40**
that I last saw him alive on **July 16**, 19 **40**
and that death occurred on the date and hour stated above.

Immediate cause of death
Syphilitic Heart Disease
Atherosclerosis, General
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **JH**

PHYSICIAN
Major findings: **None**
Of operations _____
Of autopsy **None**
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? _____

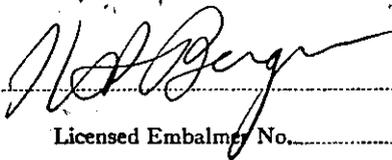
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **James J. Murphy**, (M. D. or other) **7/16/40**
Address **315 Lafayette** Date signed _____

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

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. _____

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.