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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

AUG 14 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24082

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 2692

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

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: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 (Specify whether years, months or days)
In this community: 4 months

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City
(If outside city or town limits write "RURAL")
(d) Street No.: 1124 Paseo
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME: FRANK T. GALBRAITH
Frank T. Galbraith
3. (b) If veteran, name war: No
3. (c) Social Security No.: None
4. Sex: Male
5. Color or race: Negro
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: Feb (Month) 25 (Day) 40 (Year)

8. AGE: Years | Months: 4 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Kansas City (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Child
11. Industry or business: None
FATHER
12. Name: Wm Galbraith
13. Birthplace: Lexington (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name: Elizabeth Rowdels.
15. Birthplace: Oklahoma (City, town, or county) (State or foreign country)
16. (a) Informant: Wm. Galbraith
(b) Address: 1109 Paseo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-6-40 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~: Lincoln
18. (a) Signature of funeral director: Flynn + Greenstreet
(b) Address: 1819 E. 15 KC Mo.
19. (a) July 5, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 3-40 year ..... hour ..... min. 12 midnight
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw him alive on ..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death: Pyloric Stenosis — Duration
Due to: 15 D
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations:
Of autopsy:

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: Russell W. Fenn (M. D. or other)
Address: 2 E 9th Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Edie Evans

Licensed Embalmer No. 3836

P. O. Address 1819 E 18th KC 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.