

Registration District No. 318

Primary Registration District No. 2001

613

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(c) Name of hospital or institution: St. John Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether
In this community _____
years, months or days) 4 1/2

3. (a) PRINT FULL NAME Virginia June Galbraith

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Thomas B. Galbraith 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased June 22 1887
(Month) (Day) (Year)

8. AGE: Years 53 Months 1 Days 2 If less than one day hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 12. Name Wm. Price Doran
13. Birthplace not known Tennessee
14. Maiden name Conelia Madden
15. Birthplace not known Virginia

16. (a) Informant Thomas B. Galbraith

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof July 27, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cem.

18. (a) Signature of funeral director H. H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 7-29-40 (b) W. E. Handley M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 328 W. Webster
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1940 hour 9 minute 40 p.m.

21. I hereby certify that I attended the deceased from 7/19
1940, to 7/24, 1940

that I last saw her alive on 7/24, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Acute Gangrenous appendicitis 7 days
Due to _____

Due to _____

Other conditions Alus & Toxemia 4 days
(Include pregnancy within 3 months of death)

Major findings: Gangrenous
Of operations Appendix
Of autopsy No

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?

904 (Specify type of place)

While at work? (e) Means of injury

23. Signature W. E. Handley (M. D. or other) 1

Address Springfield Mo Date signed 7/25/40

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.