

Registration District No. 12000

Primary Registration District No. 5553B 42 35

Registrar's No. 206

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Lee's Summit  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
408 So Market St.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days 20 yr

3. (a) PRINT FULL NAME

James Galloway

3. (b) If veteran, name war

3. (c) Social Security No. \_\_\_\_\_

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Delia Galloway

6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased May 19 1857  
 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>81</u>	<u>6</u>	<u>9</u>	hr. _____ min. _____

9. Birthplace

Warren County Ky.  
 (City, town, or county) (State or foreign country)

10. Usual occupation

Farmer Carpenter

11. Industry or business

Farm

12. Name

Flem Galloway

13. Birthplace

unknown Ky.  
 (City, town, or county) (State or foreign country)

14. Maiden name

Dishman

15. Birthplace

unknown Ky.  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature

Mr James Galloway

(b) Address

Lee's Summit mo

17. (a) Burial

(b) Date thereof

11-30-40  
 (Month) (Day) (Year)

(c) Place: burial or cremation

Lee's Summit mo

18. (a) Signature of funeral director

H B Langford

(b) Address

Lee's Summit mo

19. (a) 11-30-40

(b)

Sara G Barnes  
 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
 (c) City or town Lee's Summit  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 408 South Market St.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 28  
 year 1940 hour 4:00 minute A. M.

21. I hereby certify that I attended the deceased from Nov. 25, 1940, to Nov. 28, 1940  
 that I last saw him alive on Nov. 27, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death

Coronary occlusion

Duration

1 day

Due to \_\_\_\_\_

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? 9 39  
 (Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Cliff L Miller (M. D. or other)

Address Lee's Summit mo Date signed 11/29/40

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.

---

---

**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 *H. B. Longford*

Licensed Embalmer No. *3833*

P. O. Address *Pelee Summit*

**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.