

WHITE PRINTING, WITH UNFADING INK---THIS IS 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.

Missouri 1941

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

7460
Do not use this space.

1. PLACE OF DEATH

(a) County Linn Registration District No. 689 490
 (b) Township Union Primary Registration District No. 5657 Registered No. 2
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Sara Galloway

(a) Residence, No. Rural St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm Galloway
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug-16-1877
 7. AGE YEARS 63 MONTHS 5 DAYS 15 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Linn Co Mo

FATHER 13. NAME James Henderson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER 15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Clarence Galloway Whiteside Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Old Liberty DATE Feb-2-1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gosch & Sons Co. Galena Mo.

20. FILED Feb 3rd 1941 H.M. Good Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 1- 1941

22. I HEREBY CERTIFY, That I attended deceased from 11/6, 1940, to 2/1, 1941

I last saw her alive on 2/1, 1941. Death is said to have occurred on the date stated above, at 5:30 p.m.

The principal cause of death and related causes of importance were as follows:

Broncho-pneumonia Date of onset 1/20-41
Chronic myocarditis
Cerebral hemorrhage 11/6-1940

Other contributory causes of importance:
Chronic myocarditis
Cerebral hemorrhage

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) J. B. Hoeg M. D.
439 (Address) Whiteside Mo.

O. H. Damon (Licensed Embalmer's Statement on Reverse Side)

I X18665

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 *Norman E. Gosh*.....

Licensed Embalmer No. *2342*.....

P. O. Address *Eolia, 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.