

No. 13-1  
17-39  
X

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED MAY 9 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

14979

State File No. 97

Registration District No. 461

Primary Registration District No. 3024

Registrar's No.

1. PLACE OF DEATH:  
 (a) County Lafayette  
 (b) City or town Lunington  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: city  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MO (b) County Lafayette  
 (c) City or town Lunington  
(If outside city or town limits, write "RURAL")  
 (d) Street No. city  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A? 0 years.

3. (a) PRINT FULL NAME Filmore Galle  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month April day 11  
 year 1941 hour 8 minute 30 P. M.  
 21. I hereby certify that I attended the deceased from April 7  
1941, to April 11, 1941;  
 that I last saw him alive on April 11, 1941;  
 and that death occurred on the date and hour stated above.

4. Sex ma 5. Color or race W  
 6. (a) Single, widowed, married, divorced 2  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: April 20 1857  
(Month) (Day) (Year)

Immediate cause of death hemorrhage into brain Duration \_\_\_\_\_  
 Due to head fall and head injury  
 Due to heavy drinking of whiskey  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 83 Months 11 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
 9. Birthplace Camden MO  
(City, town, or county) (State or foreign country)  
 10. Usual occupation laborer

PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.  
 Major findings: no  
 Of operations no  
 Of autopsy none

MOTHER FATHER {  
 12. Name Peter Galle  
 13. Birthplace not known  
(City, town, or county) (State or foreign country)  
 14. Maiden name not known  
 15. Birthplace not known  
(City, town, or county) (State or foreign country)  
 16. (a) Informant Louis Galle  
 (b) Address Lunington MO  
 17. (a) Burial (b) Date thereof April 14-1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Lunington MO  
 18. (a) Signature of funeral director W. W. Smith  
 (b) Address Lunington MO  
 19. (a) April 14-1941 (b) Deled Bates  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) no accident  
 (b) Date of occurrence April 10/11/1941  
 (c) Where did injury occur? Fell on pavement  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
87A city head cut  
(Specify type of place)  
 While at work? no (e) Means of injury \_\_\_\_\_  
 23. Signature John C. ... (M. D. or other) D  
 Address Lunington Date signed May 14/41

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

200

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 5-7-41

**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 Garret J. Stempel

Licensed Embalmer No. 3256-

P. O. Address Livingston, N.C.

**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, fact should be so stated above.**

Registration District No. 461

Primary Registration District No. 3024

Registrar's No.

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

1. PLACE OF DEATH:  
 (a) County Lafayette  
 (b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: \_\_\_\_\_  
(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)

3. (a) PRINT FULL NAME Filmore Galle  
 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 \_\_\_\_\_  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Apr 20 1857  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>83</u>	<u>02</u>	<u>11</u>	<u>21</u>	hr. min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name \_\_\_\_\_  
 13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
 14. Maiden name \_\_\_\_\_  
 15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
 (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_  
 19. (a) April 14 (b) Dolan Bates  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Apr day 11  
 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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 J. L. Cape (M. D. or other) \_\_\_\_\_  
 Address Lexington Mo. Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

