

FILED SEP 22 1943 180
Registration District No. _____

Primary Registration District No. **5385**

Registrar's No. **42**

1. PLACE OF DEATH:
(a) County Dent
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Station Hospital, Ft. Leonard Wood, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution DOA
In this community Transient **3** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State New Jersey (b) County Unknown **999**
(c) City or town North Bergen **28**
(If outside city or town limits, write "RURAL")
(d) Street No. 610 Columbia Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____ **2**

3. (a) PRINT FULL NAME James Edward Gallagher 2nd Lt.
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 4
year 1943 hour about 4 minute 00 P.M.

4. Sex Male 0 5. Color or race White 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 14 1917
(Month) (Day) (Year)

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.

8. AGE: Years Months Days If less than one day
26 5 22 _____ hr. _____ min.

Immediate cause of death Multiple contusions, lacerations and fractures
Due to Airplane Crash

9. Birthplace Unknown (City, town, or county) (State or foreign country) **9**
10. Usual occupation U.S.A.A.C. 0-799003
11. Industry or business Reeves Prov. Gp. 346 Bomb Gp.

Due to _____
Other conditions None (Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy None

MOTHER FATHER
12. Name James E. Gallagher Sr.
13. Birthplace Unknown (City, town, or county) (State or foreign country) **9**
14. Maiden name Catherine Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country) **A**

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

16. (a) Informant Army Records
(b) Address Army Air Base Dyersburg, Tenn.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 8, 1943
(Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director W.E. Heerman
(b) Address Lebanon Mo
19. (a) Sept 7, 1943 (Date received local registrar) (b) Robert A Murray (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident **033**
(b) Date of occurrence Sept. 4, 1943
(c) Where did injury occur? Rural Dent Mo:
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Airplane crash--rural
While at work? Yes (Specify type of place) Airplane & ground
(e) Means of injury
23. Signature Walter S. Jostling, Capt M.C. of 2nd (M. D. or other) _____
Address Ft. Leonard Wood, Mo. Date signed _____

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

RECEIVED

District Health Officer No. 5

District File Number 943585-

Date Filed 9-21-43

JAN 27 1951

OFFICE OF THE DISTRICT HEALTH OFFICER

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 myself, Registered Apprentice No. _____ working under my personal supervision.

Signed W. E. Holman

Licensed Embalmer No. 4107

P. O. Address Lubaron 7

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.

No. 1-13
-17
PI X-1030

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 100

Primary Registration District No. 5385

Registrar's No. 42

1. PLACE OF DEATH

(a) County Dent
(b) City or town Rural - Meramec Twp
(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 _____
year, months or days)

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 _____

3. (a) PRINT FULL NAME

James Edward Gallagher 27th

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day _____
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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 S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased mar 14
(Month) (Day) (Year)

AGE: Years 26 Months 5 Days _____ If less than one day _____ min.

8. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY--USE U.S. GOVERNMENT INK--MAKE PERMANENT RECORD

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6
A

31543