

FILED DEC 13 1943

318

Primary Registration District No.

1003

10589

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days 0
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3655 Flad Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

William R. Galloway

3. (b) If veteran,

name war Nil

3. (c) Social Security

No. 489-16-1994

4. Sex Male

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased May

6 1877

8. AGE:

Years

Months

Days

If less than one day

66

6

23

hr. min.

9. Birthplace Pleasant Hill

Illinois

10. Usual occupation Candy Maker

11. Industry or business _____

12. Name James A. Galloway

13. Birthplace Pleasant Hill

Illinois

14. Maiden name Sylvia Cragmiles

15. Birthplace Pleasant Hill

Illinois

16. (a) Informant Emma Galloway

(b) Address 3655 Flad Ave.

17. (a) Removal (b) Date thereof 12-1-43

(c) Place: burial or cremation Nebo, Illinois

18. (a) Signature of funeral director Albert H. Hoppe, Inc.

(b) Address 4700 Washington Blvd.

19. (a) DEC 2 1943 (b) J. F. Bredbeck

(Date received local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 29
year 1943 hour 10 pm minute _____ M.

21. I hereby certify that I attended the deceased from Nov 26
43, 19____, to Nov 29 43 19____;
that I last saw him alive on Nov 29 19____
and that death occurred on the date and hour stated above.

Immediate cause of death

Cardiac Regeneration

Duration

Indefinite

Due to _____

Due to _____

Other conditions Acute upper Respiratory infection
(include pregnancy within 3 months of death)

PHYSICIAN

Major findings:

Of operations _____

Of autopsy _____

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?

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

23. Signature Quenne J. [unclear] (M. D. number) _____
Address 927 [unclear] Date signed 12-1-43

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

MOTHER FATHER

84F

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

Albert G. Kopp

Licensed Embalmer No.....

2971

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, fact should be so stated above.