

FILED JUN 23 1944  
Registration District No. 2

Primary Registration District No. 6148

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

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1. PLACE OF DEATH:  
 (a) County Stoddard  
 (b) City or town Essex, Rural  
 (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 \_\_\_\_\_  
 In this community Years  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County Stoddard  
 (c) City or town Essex, Rural  
 (d) Street No. \_\_\_\_\_  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

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

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month May day 16th  
 year 1944 hour 5 minute \_\_\_\_\_ P. M.

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Dec. 23 1867  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 1st 1944 to May 16 1944  
 that I last saw him alive on May 16 1944  
 and that death occurred on the date and hour stated above.

8. AGE: Years 76 Months 4 Days 23  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Anginal Pectoris  
 Duration 19

9. Birthplace Bloomfield Mo.  
 (City, town, or county) (State or foreign country)

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

10. Usual occupation Housewife

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER  
 11. Industry or business \_\_\_\_\_  
 12. Name Robert Walker  
 13. Birthplace Mo.  
 14. Maiden name Missouri E. Link  
 15. Birthplace Mo.

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? \_\_\_\_\_  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

16. (a) Informant Robert Galloway  
 (b) Address Essex, Mo. R. # 2  
 17. (a) Burial (b) Date thereof 5-17-44  
 (c) Place: burial or cremation Walker Cemetery

While at work? \_\_\_\_\_  
 (Specify type of place) (c) Means of injury \_\_\_\_\_  
 23. Signature J. P. Brannon (M. D. or \_\_\_\_\_)  
 Address J. P. Brannon, Mo. Date signed 5-16-44

18. (a) Signature of funeral director Chiles Und, Co.  
 (b) Address Bloomfield, Mo.  
 19. (a) 2/20-1944 (b) Yeard E. Moore  
 (Date received local registrar) (Registrar's signature)

RECEIVED

District Health Office No. 2,

District File Number 644-833

Date Filed 6-8-44

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**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 N. E. Embalming.....

Licensed Embalmer No.....

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.**