

S. No. 2
DM-5-42
Rev. 5-17-39
I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr/ Freeman
16912
State File No.....
Registrar's No..... 72

FILED JUN 2 1945
128-130
Registration District No.....

Primary Registration District No. 5467A-5439

1. PLACE OF DEATH:
(a) County **GREENE**
(b) City or town **Rural Taylor Township**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Route # 2 Springfield, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community **65 Years**
years, months or days) (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Greene**
(c) City or town **Rural Taylor Township**
(If outside city or town limits, write "RURAL")
(d) Street No. **Route # 2 Springfield, Mo.**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Nancy Galloway**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **No**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **4**
year **1945** hour **5** minute **5 p.m.**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Charles A. Galloway**
6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **Oct. 2 1879**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **May 10 - 1945** to **May 4 1945**
that I last saw **her** alive on **May 4 - 1945**
and that death occurred on the date and hour stated above.
Immediate cause of death **Valvular heart lesion**
about 10 yrs
Duration

8. AGE: Years Months Days If less than one day
65. **7** **2** hr. min.

Due to.....
Due to.....

9. Birthplace **Greene County Missouri**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

Other conditions **enlarged thyroid**
(Include pregnancy within 3 months of death)

11. Industry or business
12. Name **Ambrose Fondren**
13. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)
14. Maiden name **Nancy Yeary**
15. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Fred Galloway**
(b) Address **Route # 2 Springfield, Mo.**
17. (a) **Burial** (b) Date thereof **5/6/45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Danforth Cemetery**

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.....

18. (a) Signature of funeral director **H. H. Lohmeyer**
(b) Address **Springfield, Mo.**
19. (a) **5/5/45** (b) **Freeman**
(Date received local registrar) (Registrar's signature)

23. Signature **Dr. Freeman** D. or other.....
Address **Springfield, Mo** Date signed **5/6/45**

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

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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 Walter E Hamilton
Licensed Embalmer No. 3808
P. O. Address Springfield 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, fact should be so stated above.