

No. 2
2-45
17-39

LED

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **MISSOURI**
(b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **ST. JOHN'S HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 DAYS**
(Specify whether In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **ST. LOUIS**
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL.")
(d) Street No. **2424 LEMP**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **LLOYD R. GALLUP**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **ALMA** 6. (c) Age of husband or wife if alive **30** years
7. Birth date of deceased **APRIL 12 1896**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 10 19 hr. min.

9. Birthplace **MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **FUEL INSPECTOR**

11. Industry or business **WATER METER DEPT.**

12. Name **JOHN GALLUP**

13. Birthplace **MO**
(City, town, or county) (State or foreign country)

14. Maiden name **SARA YOUNG**
(City, town, or county) (State or foreign country)

15. Birthplace **MO.**
(City, town, or county) (State or foreign country)

16. (a) Informant **ALMA GALLUP.**

(b) Address **2424 LEMP**

17. (a) **BURIAL** (b) Date thereof **MAR 4 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **NEW ST. MARCUS**

18. (a) Signature of funeral director **Thomas Kutis**

(b) Address **2906 GRAVOIS**

19. (a) **MAR 3 1947** (b) **J. F. Bredeek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAR.** day **1**
year **1947** hour **8** minute **A.M.**

21. I hereby certify that I attended the deceased from **Nov 46**, 19____, to **Death**, 19____; that I last saw him alive on **Feb. 25**, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma**
Due to **Carcinoma of stomach**
Duration **?**

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

Major findings: **Dec 7 1946 - gastric media for ca**
Of operations _____
Of autopsy _____

PHYSICIAN

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 **John J. Busle** (M. D. or other) **M.D.**
Address **5203 Chipman** Date signed **3-3-47**

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

MOTHER FATHER

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.....

Leo J Budde

Licensed Embalmer No. *3989*

P. O. Address.....

St Louis 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.