S. No. 2
M—1/47
r. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41674

FILED JAN 2 1948

Registration District No. 1989 — Primary Registration District No. 1002 — Registrar's No. 5346

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1610 Drury
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: no (Specify whether years, months or days)

In this community: 16 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Jackson 48

(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No.: 1610 Drury 8
(If rural, give location) 0

(e) Citizen of foreign country? no (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: Mrs. Millie Galvin

3. (b) If veteran, name war: no

3. (c) Social Security No.: no

4. Sex: Female

5. Color or race: Wh

6. (a) Single, widowed, married, divorced: Wid.

6. (b) Name of husband or wife: Robert Galvin

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

7. Birth date of deceased: December 30 1870 (Month) (Day) (Year)

8. AGE: Years 77 Months 0 Days ~~16~~ 15 If less than one day hr. min.

9. Birthplace: New Castle, Ind. (City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Joshua L. Gray
13. Birthplace: New Jersey (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Sarah Jane Davis
15. Birthplace: New Castle, Ind. (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Dollie Fitzpatrick
(b) Address: 1610 Drury

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 12/21/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Ft. Scott, Kans.

18. (a) Signature of funeral director: John P. Sheil
(b) Address: Kansas City, Mo.

19. (a) 12-20-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 18 year ~~1940~~ 1947 hour 11:32 minute P M.

21. I hereby certify that I attended the deceased from 1940, 19..., to 12-18-, 1947, that I last saw her alive on 12-18-, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic myocarditis & acute pulmonary edema	Years
Due to: Hyperplasia and diabetes mellitus	Acute years
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations: —
Of autopsy: —

PHYSICIAN — Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: L. Raymond Hall (M. D. or other) D.O.
Address: 2603 Indep. Blvd. Date signed: 12-20-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 _____

Licensed Embalmer No. 3625

P. O. Address F. C. 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.