

S. No. 2
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v. 5-17-39
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42252

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 17 1947

Registration District No. 178

Primary Registration District No. 4284

Registrar's No. 107

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

1. PLACE OF DEATH Lewis

(a) County La Belle

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

(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 one year
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Commidore Perry Galbraith

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 widowed

6. (b) Name of husband or wife _____

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

7. Birth date of deceased October 9, 1854
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>93</u>	<u>1</u>	<u>16</u>	hr. _____ min.

9. Birthplace New Port Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

12. Name A. J. Galbraith

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

14. Maiden name Sarah Perry
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Mennie Sharp

(b) Address La Belle, Missouri

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 11/28/47
(Month) (Day) (Year)

(c) Place: burial or cremation Lewistown Cemetery

18. (a) Signature of funeral director [Signature]
La Belle, Missouri

(b) Address _____

19. (a) 12-8-47
(Date received local registrar)

(b) [Signature]
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis

(c) City or town Lewistown
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 24th
year 1947 hour 7 minute 30 M.

21. I hereby certify that I attended the deceased from November 19, 1947 to Nov. 25, 1947; that I last saw him alive on Nov. 25, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Influenza

Duration 5 days

Due to Cardio-Vascular disease

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: [Signature]
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? [Signature] (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other)

Address La Belle Mo. Date signed 11/26/47

RECEIVED
District Health Officer No. 10
District File Number 12:47:1755
Date Filed DEC 15 1947

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 myself

....., Registered Apprentice No.
working under my personal supervision.

Signed J. Gloder Jr.
Licensed Embalmer No. 4328
P. O. Address La Belle, 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.