

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2687
State File No.

BIRTH NO. 49-004217 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 872

18

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS MATERNITY HOSPITAL		d. STREET ADDRESS (If rural, give location) 1224 SO. 39th. ST.	

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
		INFANT	GALLOWAY	JANUARY 17 49

5. SEX male 2	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH JANUARY 13 49	9. AGE (In years last birthday) IF UNDER 1 YEAR Days IF UNDER 11 HRS. Hours IF UNDER 11 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ST. LOUIS MISSOURI	12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME JOHN HENRY GALLOWAY	13b. MOTHER'S MAIDEN NAME PHOEBE MAE EVANS	14. NAME OF HUSBAND OR WIFE <i>J.H. Galloway 1224 S 39th St</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S SIGNATURE OR NAME <i>J.H. Galloway - 1224 S 39th St</i>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Birth injury of cerebellum</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>1600</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>autopsy - Subtentorial hemorrhage.</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from JANUARY 13 49 to JANUARY 17 19 49 that I last saw the deceased alive on January 17 49, and that death occurred at 8:50P m., from the causes and on the date stated above.

23a. SIGNATURE <i>P.T. Hard M.D.</i>	(Degree or title)	23b. ADDRESS <i>630 S Kingshighway</i>	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE JAN 31 1949	24c. ANATOMICAL INTERMENT OR CREMATORY	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. JAN 31 1949	REGISTRAR'S SIGNATURE <i>J.B. Pasater</i>	FUNERAL DIRECTOR'S SIGNATURE <i>Proctor Mort. Service</i>	ADDRESS <i>4104 Manchester</i>
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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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

Signed.....
Student Embalmer

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.