

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21044

State File No. \_\_\_\_\_  
Registrar's No. **5629**

No. 3  
10-48

53L-9 1949

BIRTH NO. **#3786** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place) <b>0</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>17</b>							
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1.</b>			d. STREET ADDRESS (If rural, give location) <b>25 = 2525 Clark Ave.,</b>									
3. NAME OF DECEASED (Type or Print) a. (First) <b>EARL</b> b. (Middle) <b>GALVIN</b> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <b>May 25th, 1949</b>									
5. SEX <b>MALE 0</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>DIVORCED 3</b>	8. DATE OF BIRTH <b>May 31, alt - 62</b>	9. AGE (In years last birthday) <b>62</b>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="font-size: small;">IF UNDER 1 YEAR</td> <td style="font-size: small;">IF UNDER 11 HRS.</td> </tr> <tr> <td style="font-size: x-small;">Months</td> <td style="font-size: x-small;">Days</td> </tr> <tr> <td style="font-size: x-small;">Hours</td> <td style="font-size: x-small;">Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 11 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 11 HRS.											
Months	Days											
Hours	Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nil</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>								
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME <b>John Galvin</b>	13b. MOTHER'S MAIDEN NAME <b>Emma Franklin</b>	14. NAME OF HUSBAND OR WIFE <b>unknown</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>W. H. Newark - City Hospital</i>									
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, ashenia, etc. It means the disease, injury, or complication which caused death.			<p align="center"><b>MEDICAL CERTIFICATION</b></p> <p align="center">I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary tuberculosis</b></p> <p align="center">INTERVAL BETWEEN ONSET AND DEATH</p> <p align="center">ANTECEDENT CAUSES</p> <p align="center">Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p align="center">DUE TO (b) _____</p> <p align="center">DUE TO (c) _____</p> <p align="center">II. OTHER SIGNIFICANT CONDITIONS</p> <p align="center">Conditions contributing to the death but not related to the disease or condition causing death.</p>									
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
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) <b>13th</b>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)								
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>M 27</b>											
22. I hereby certify that I attended the deceased from: <b>5/3/49</b> , 19__, to <b>5/25/49</b> , 19__, that I last saw the deceased alive on <b>5/25/49</b> , 19__, and that death occurred at <b>10:20am.</b> , from the causes and on the date stated above.												
23a. SIGNATURE (Degree or title) <i>John W. Murphy, M.D.</i>			23b. ADDRESS <b>1515 Lafayette Ave.,</b>		23c. DATE SIGNED <b>6/2/49</b>							
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>JUN 30 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>		24d. LOCATION (City, town, or county) (State)								
DATE REC'D BY LOCAL REG. <b>JUN 30 1949</b>		REGISTRAR'S SIGNATURE <i>J. B. Laoster</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Rowland Mortuary Service 4104 Manchester Ave.</b>								

WRITE PLAINLY—USING 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\_\_\_\_\_

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

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.