

FILED AUG 6 1949 THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. 23391  
Registrar's No. 3011

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. MARY'S HOSPITAL</b>		d. STREET ADDRESS (If rural, give location) <b>2023 EAST 70<sup>th</sup> TERRACE</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Hal</b> b. (Middle) <b>Martin</b> c. (Last) <b>GALBRAITH</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>JULY-8-1949</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	
8. DATE OF BIRTH <b>OCT. 9, 1887</b>		9. AGE (In years last birthday) <b>61 YRS.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telegraph operator</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>M.P. Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Hope, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	

13a. FATHER'S NAME <b>William Galbraith</b>		13b. MOTHER'S MAIDEN NAME <b>Diana Martin</b>		14. NAME OF HUSBAND OR WIFE <b>Phara Galbraith</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>102-18-0770</b>		17. INFORMANT'S SIGNATURE OR NAME, ADDRESS <b>Mrs Phara Galbraith K.C.Mo</b>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>NO</b>		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>acute coronary insufficiency</b>		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Coronary Atherosclerosis</b>					
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) <b>Hypertrophy of heart</b>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>Pathologist 4201</b>		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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **10:15 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>W. E. Upsher M.D.</b>		23b. ADDRESS <b>2800 Main</b>		23c. DATE SIGNED <b>7/9/49</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>JULY-11-1949</b>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <b>HOSPITAL GROUNDS, KANSAS</b>	
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DATE REC'D BY LOCAL REG. <b>7-11-49</b>		REGISTRAR'S SIGNATURE <b>Geraldine Holmes</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>D.W. Newcomer</b>		ADDRESS <b>1531 BRUSH GREEN BLVD KANSAS CITY, MO.</b>	
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(Licensed Embalmer's Statement on Reverse Side)

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

**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 *John C. Fraking* \_\_\_\_\_

Licensed Embalmer No. *4483* \_\_\_\_\_

P. O. Address *Kansas City, 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.