

FILED OCT 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35148

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9003**

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 Christian Hospital		d. STREET ADDRESS (If rural, give location) 4425 West Pine	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) James	b. (Middle) William	c. (Last) Galloway	(Month) Oct. (Day) 18 (Year) 1949
5. SEX Male ()	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 9, 1874
9. AGE (In years last birthday) 74		10. IF UNDER 1 YEAR: Months _____ Days _____	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Decorator	10b. KIND OF BUSINESS OR INDUSTRY & Painter	11. BIRTHPLACE (State or foreign country) Warrick Co., Indiana	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME James Galloway	13b. MOTHER'S MAIDEN NAME Nancy West	14. NAME OF HUSBAND OR WIFE Mary Ellen Galloway
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 493-20-5753	17. INFORMANT'S SIGNATURE OR NAME Mary Galloway ADDRESS 4425 West Pine
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PRIMARY ANEMIA, TYPE NOT DETERMINED		INTERVAL BETWEEN ONSET AND DEATH -3
	2. OTHER SIGNIFICANT CONDITIONS NEW GROWTH'S BOTH KIDNEYS AND OMENTUM (MICROSCOPIC NOT COMPLETE)		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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) (STATE) 50
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? FAIR

22. I hereby certify that I attended the deceased from **Oct 3, 1949**, to **Oct 18, 1949**, that I last saw the deceased alive on **Oct 17, 1949**, and that death occurred at **5:50 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE John M. Swiney (Name and title)	23b. ADDRESS 1014 Thekla Ave Shawnee	23c. DATE SIGNED 10/19/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-20-49	24c. NAME OF CEMETERY OR CREMATORY Patterson	24d. LOCATION (City, town, or county) (State) Potosi, Mo.
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DATE REC'D BY LOCAL REG. OCT 19 1949	REGISTRAR'S SIGNATURE J. B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

intentional fraud - sit to not know

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 Me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Etienne R. Remelin

Licensed Embalmer No.

4283

P. O. Address

St. Louis, 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.