FILED JAN 12 1952

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41085

State File No.

BIRTH NO. REG. DIST. NO. 88 PRIMARY REG. DIST. NO. 5326 Registrar's No. 35

280

1. PLACE OF DEATH
a. COUNTY Crawford
b. CITY OR TOWN Rural Meramec
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY Crawford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Steelville 0750
d. STREET ADDRESS (If rural, give location) Star Route 5

3. NAME OF DECEASED (Type or Print) a. (First) ANNA b. (Middle) BELLE c. (Last) GALLION

4. DATE OF DEATH (Month) 12 (Day) 22 (Year) 51

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Sept 23, 1893
9. AGE (In years last birthday) 58 IF UNDER 1 YEAR Months 2 Days 29 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Youngstown, Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Informant Doesn't Know
13b. MOTHER'S MAIDEN NAME "Litt"
14. NAME OF HUSBAND OR WIFE Wm Gallion

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME William Gallion, ADDRESS Steelville, Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cardiac Decompensation. — INTERVAL BETWEEN ONSET AND DEATH 3 HOURS

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Chronic Myocarditis.

DUE TO (c)

II. 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 4222
20. AUTOPSY? YES ☐ NO ☑

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-22, 1951, *to* 12-22, 1951, *that I last saw the deceased alive on* 12-22, 1951, *and that death occurred at* 2:10 A *m., from the causes and on the date stated above.*

23a. SIGNATURE John Charles Doulick Jr. (Degree or title) MD
23b. ADDRESS Steelville, Mo.
23c. DATE SIGNED 12-22-51

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY Kinder Cemetery
24d. LOCATION (City, town, or county) Cuba (State) Mo.

DATE REC'D BY LOCAL REG. 1-9-52
REGISTRAR'S SIGNATURE [illegible]
25. FUNERAL DIRECTOR'S SIGNATURE [illegible] ADDRESS Cuba, Mo.

(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 .....

Licensed Embalmer No. 3472

P. O. Address Cuba, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.