

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **34982**
4166

FILED OCT 25 1952

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (In this place) 41 yrs.		d. STREET ADDRESS (If rural, give location) 2734 Wenzel	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2734 Wenzel		d. STREET ADDRESS (If rural, give location) 2734 Wenzel	
3. NAME OF DECEASED (Type or Print) a. (First) Bert		b. (Middle) _____	
c. (Last) GALLOWAY		4. DATE OF DEATH (Month) (Day) (Year) Oct. 11, 1952	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 29, 1876
9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR: Months _____ Days _____	
10. IF UNDER 1 MIN. Hours _____ Min. _____		11. BIRTHPLACE (City and State or Foreign Country) Carthage, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Archibald Galloway	
13b. MOTHER'S MAIDEN NAME Margaret E. Shannon		14. NAME OF HUSBAND OR WIFE Lola E. Galloway	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 186-03-1234	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Lola E. Galloway		ADDRESS 2734 Wenzel, KC. Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES		DUE TO (b) Mal Nutrition	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) Ulcerating Carcinoma of Esophagus	
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	
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)	
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 10-10-52 to 10-11-52 that I last saw the deceased alive on 10-10-52 and that death occurred at 10 A m., from the causes and on the date stated above.	
23a. SIGNATURE B. D. Reese		(Degree or title) _____	
23b. ADDRESS 3309 E 12		23c. DATE SIGNED 10-12-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-14-52	
24c. NAME OF CEMETERY OR CREMATORY Forest Hill		24d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
DATE REC'D BY LOCAL REG. 10-14-52		REGISTRAR'S SIGNATURE Beraldine Smith	
25. FUNERAL DIRECTOR'S SIGNATURE Melody-McGilley-Bylar		ADDRESS Kansas City, Mo.	

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

Dalloway

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

Glen E. Heck

Licensed Embalmer No. 4063

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.