

**THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

43426

State File No. _____

FILED JAN 10 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11646**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 11646	
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. LENGTH OF STAY (in this place) 40 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location) 2328 Pine St			
3. NAME OF DECEASED (Type or Print) a. (First) George			b. (Middle) W		c. (Last) Galbreath		4. DATE OF DEATH (Month) (Day) (Year) Dec. 7 1952
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower		8. DATE OF BIRTH Nov. 6, 1880		9. AGE (in years last birthday) 72	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (City and State or Foreign Country) Missouri			12. CITIZEN OF WHAT COUNTRY? U S A	
13a. FATHER'S NAME Henry Galbreath			13b. MOTHER'S MAIDEN NAME Harriett ?		14. NAME OF HUSBAND OR WIFE Not known		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Elizabeth Rhodes, 2601 N Whittier ADDRESS _____			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Dehydration and Malnutrition ANTECEDENT CAUSES Undetermined <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) Hypertensive Cardiovascular Disease II. OTHER SIGNIFICANT CONDITIONS Hypertrophy of Prostate, Benign <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					INTERVAL BETWEEN ONSET AND DEATH Undet.	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 443X			
22. I hereby certify that I attended the deceased from 12-5 , 19 52 , to 12-7 , 19 52 , that I last saw the deceased alive on 12-7 , 19 52 , and that death occurred at 9:30p m. , from the causes and on the date stated above.							
23a. SIGNATURE Herbert H. Harris, M.D. (Degree or title)				23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 12-11-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) 0		24b. DATE 12-31-52	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State) St. Louis, MO.		
DATE REC'D BY LOCAL REG. DEC 18 1952		REGISTRAR'S SIGNATURE J. C. Smith		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service ADDRESS _____			

(Licensed Embalmer's Statement on Reverse Side)

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

300
10.48

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.