

FILED JUN 10 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19408

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5346**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Madison	
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 Wood River	
c. LENGTH OF STAY (In this place) 3 days		d. STREET ADDRESS (If rural, give location) 424 Old St. Louis Road	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital			

3. NAME OF DECEASED (Type or Print) Samuel	a. (First)	b. (Middle)	c. (Last) GALLAY	4. DATE OF DEATH May 26, 1953
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) Ab. 72	If UNDER 1 YEAR Months	If UNDER 1 YEAR Days	If UNDER 1 HRS. Hours	If UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dealer	10b. KIND OF BUSINESS OR INDUSTRY Scrap Metal	11. BIRTHPLACE (State or foreign country) Poland	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Bernard Gallay	13b. MOTHER'S MAIDEN NAME Unkno wn	14. NAME OF HUSBAND OR WIFE Rosalie Gallay
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Rosalie Gallay	ADDRESS 424 Old St. Louis Rd.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardio-Vasc. Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardio-Vasc. Disease		
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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4/3X
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22. I hereby certify that I attended the deceased from **May, 1951**, to **May, 1953**, that I last saw the deceased alive on **May 26, 1953**, and that death occurred at **6:18 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Mrs. Alex M.D.	(Degree or title)	23b. ADDRESS 601 Humboldt Bldg.	23c. DATE SIGNED 5/27/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5/28/1953	24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth	24d. LOCATION (City, town, or county) (State) University City, Mo
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAY 28 1953 J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial	ADDRESS 4715 McPherson Ave.
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m & B. (Licensed Embalmer's Statement on Reverse Side)

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Quinn J. Rudwig

Licensed Embalmer No. 4229

Signed.....
Student Embalmer

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.