

FILED APR 14 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **8647**  
**1397**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, write RURAL and give town) <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>60 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF (If not in hospital or institution, give street address of location) <u>St. Mary's Hosp.</u>				e. STREET ADDRESS (If rural, give location) <u>328 S. Wheeling</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Selma</u>		b. (Middle) <u>A.</u>		c. (Last) <u>GALSTER</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>28</u> (Year) <u>54</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>7/2/1874</u>			
9. AGE (In years last birthday) <u>79</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>GERMANY</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>CARL FORSTMANN</u>		13b. MOTHER'S MAIDEN NAME <u>MARY FRIER</u>		14. NAME OF HUSBAND OR WIFE <u>CHRISTIAN GALSTER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>GEO. E. GALSTER</u> ADDRESS <u>63<sup>rd</sup> Blue Ridge Cut-off</u>					
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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>10-15 min</u> <u>15-20 yrs</u>	
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) <u>4200</u>		21f. HOW DID INJURY OCCUR _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>March 20, 1954</u> , to <u>March 28, 1954</u> , that I last saw the deceased alive on <u>March 28, 1954</u> , and that death occurred at <u>6:15 p.m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE <u>W. V. Dodson</u>		23b. ADDRESS <u>M. A. Dodson Kansas City, Mo.</u>		23c. DATE SIGNED <u>3/29/54</u>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>3/30/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Brookings Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Raytown mo.</u>			
DATE REC'D BY LOCAL REG. <u>3-29-54</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sheil Funeral Home</u> ADDRESS <u>H. C. Mo.</u>					

(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.....  
Signature of Student Embalmer

Signed *Richard C. Carroll*.....

Licensed Embalmer No. *787*.....

P. O. Address *R. C. Moore*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.