

t. Health,
& Welfare
s. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032336
STATE FILE NUMBER

FILED SEP 29 1958

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 868A

S. 300
y. 1-57

1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Minnesota b. COUNTY Hennepin)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Minneapolis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital or institution) Memorial Handley Hospital		Length of stay in lb Unknown	d. STREET ADDRESS (If outside, give location) 124 1/2 Hennipen Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First RICHARD Middle GALDUP Last GALDUP			4. DATE OF DEATH September 5, 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1887		9. AGE (In years last birthday) 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (City and state or country) Caroll, Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Wallace D. Gallup		13b. MOTHER'S MAIDEN NAME Evelyn Wood		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Hospital Record: Handley Mem. Hosp.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Apoplexy					INTERVAL BETWEEN ONSET AND DEATH Aug. 23, 1958
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					Sept. 5, 1958
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Aug. 23, 1958 to Sept. 5, 1958 and last saw <input checked="" type="checkbox"/> him alive on Sept. 5, 1958 Death occurred at 5:00 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Thomas D. Brown M.D.			22b. ADDRESS 311 1/2 College, Springfield, Mo.		22c. DATE SIGNED 9-8-58
23a. BURIAL, CREMATION, REMOVAL REMOVAL		23b. DATE 9-10-58	23c. NAME OF CEMETERY OR CREMATORY unknown		23d. LOCATION (City, town, or county) (State) Kirkville, Missouri
24. FUNERAL DIRECTOR ADDRESS AYRE-GOODWIN: Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 9-22-58		26. REGISTRAR'S SIGNATURE Effie G. Melton	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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

Gene C. Hunter

Licensed Embalmer No. *4939*

P. O. Address *Spfld, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.~~

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

SE-01-2