

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018315

STATE FILE NUMBER

FILED MAY 25 1959

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 60

300
-57

1. PLACE OF DEATH a. COUNTY <u>St. Lawrence</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. State Sanatorium</u>		Length of stay in lb <u>19 days</u>	d. STREET ADDRESS (If outside, give location) <u>1217 W. Harrison</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Vernie</u> Middle <u>Galbraith</u> Last <u>Galbraith</u>			4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1901</u>	9. AGE (In years last birthday) <u>58</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. 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 country) <u>Springfield, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Walter W. Master</u>		13b. MOTHER'S MAIDEN NAME <u>Nettie J. Smith</u>	14. NAME OF HUSBAND OR WIFE		
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>none</u>	17. INFORMANT <u>San. records, Mo. state San., Mt. Vernon, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Postoperative transportation of colon thru anterior mediastinum with gastrocolic & ileocolic anastomosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) <u>Gangrene of ileum & cecum, postoperative</u>					<u>6 mo.</u>
DUE TO (c) <u>Squamous cell carcinoma of esophagus with metastasis to mediastinum and neck</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO OR CAUSING THE DEATH (e.g., pre-existing disease condition given in PART I (e)) <u>150X</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>6:15 a.m.</u> Month <u>April</u> Day <u>27</u> Year <u>1959</u>			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION <u>Springfield, Mo.</u>		STATE
21. I attended the deceased from <u>April 27, 1959</u> to <u>May 16, 1959</u> and last saw her alive on <u>May 16, 1959</u> Death occurred at <u>6:15 a.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					22c. DATE SIGNED <u>5-18-59</u>
22a. SIGNATURE <u>John W. Polk, MD</u>			22b. ADDRESS <u>Mt. Vernon, Mo.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>5-16-59</u>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>
24. FUNERAL DIRECTOR <u>Ralph Thieme Funeral Home, Springfield, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>5-18-59</u>		26. REGISTRAR'S SIGNATURE <u>Coel Hendricks</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAY 28 1958

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. For Vernie Galbraith

Student
Signature of Student Embalmer

Signed *R.H. Luem*

Licensed Embalmer No. 3651

P. O. Address *Sumner, Pa.*

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.