

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-014848

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. - Registrar's No. 175

AMENDED DATE AMENDED _____ INSTEAD OF _____ DOCUMENT _____ MEDICAL CERTIFICATION _____ SHOULD-READ _____ BY AFFIDAVIT OF _____

FILED MAY 9 1961

1. PLACE OF DEATH
 a. COUNTY ST. FRANCOIS
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ELVINS Length of stay in 1b _____
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Elvins, Mo Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Mo b. COUNTY St. Francois
 c. CITY OR TOWN Elvins, Mo Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last JOHN M. Gallagher
4. DATE OF DEATH Month Day Year May 4, 1961

5. SEX Male **6. COLOR OR RACE** White
7. Married **Never Married**
Widowed **Divorced**
8. DATE OF BIRTH 9/12/1882 **9. AGE (last birthday)** 78
IF UNDER 1 YEAR Months _____ Days _____ **IF UNDER 24 HR** Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (City and state or country) St. Louis, Mo
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME W.D Gallagher **13b. MOTHER'S MAIDEN NAME** Unknown
14. NAME OF HUSBAND OR WIFE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
17. INFORMANT Address George Gallagher Elvins, Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Cardiac Failure
 DUE TO (b) APoplexy
 DUE TO (c) MULTIPLE SCLEROSIS
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____
 PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO
20a. ACCIDENT **SUICIDE** **HOMICIDE**
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. Month, Day, Year _____
20d. INJURY OCCURRED WHILE AT WORK **NOT WHILE AT WORK**
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 12-19-58 to 5-3-61 and last saw her/him alive on 5-3-61
 Death occurred at 1:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M. L. Williams M.D. **22b. ADDRESS** 6006 Lendale Flat River **22c. DATE SIGNED** 5-5-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation **23b. DATE** 5-6-1961 **23c. NAME OF CEMETERY OR CREMATORY** Valle Halle **23d. LOCATION** (City, town, or county) (State) St. Louis, Mo

24. FUNERAL DIRECTOR ADDRESS R. Caldwell & Sons Flat River, Mo **25. DATE RECD. BY LOCAL REG.** May 5, 1961 **26. REGISTRAR'S SIGNATURE** Eather Rudloff

MAY 18 1961

MAY 11 1961

JUL 6 1961

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 Donald Dale Caldwell

Licensed Embalmer No. 5095

P. O. Address Flat River, 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.