

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=61-031753

STATE FILE NUMBER

AMENDED

Registration District No. 6 Primary Registration District No. 3001 Registrar's No. 21

FILED OCT 3 1961

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| 1. PLACE OF DEATH a. COUNTY Audrain | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Audrain | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Vandalia | | Length of stay in lb <i>Approx 3 yrs</i> | c. CITY OR TOWN Vandalia |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 214 W. Home | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 214 W. Home |

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| 3. NAME OF DECEASED (Type or print) First Lyle Middle LeFever Last Galloway | 4. DATE OF DEATH Month September Day 22 Year 1961 |
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| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 6-29-1891 | 9. AGE (last birthday) 70 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Ralls Co., Mo. | 12. CITIZEN OF WHAT COUNTRY U. S. A. |
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| 13a. FATHER'S NAME J. E. Galloway | 13b. MOTHER'S MAIDEN NAME Kate Le Fever | 14. NAME OF HUSBAND OR WIFE Ester Galloway |
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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 | 17. INFORMANT Address Ester Galloway, Vandalia, Mo. |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH 40 yrs 30 days |
| IMMEDIATE CAUSE (a) Rheumatic Heart Disease | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Myocardial Infarction | | |
| DUE TO (c) | | |

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| 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month, Day, Year |
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| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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 |
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| 21. I attended the deceased from June 5 1955 to 9-22-61 and last saw him alive on Sept 3 1961 Death occurred at 5:30 a m on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE O L Garcia md (Degree or title) | 22b. ADDRESS Missouri Mo | 22c. DATE SIGNED 9-25-61 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 9-24-61 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Gardens | 23d. LOCATION (City, town, or county) (State) Audrain Co., Missouri |
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| 24. FUNERAL DIRECTOR William B. Winters, Vandalia, Mo. | ADDRESS | 25. DATE RECD. BY LOCAL REG. Sept 27 1961 | 26. REGISTRAR'S SIGNATURE Mallie Fugue |
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(Licensed Embalmer's Statement on Reverse Side)

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

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 William B. Water

Licensed Embalmer No. 4169
P. O. Address Dardulia, Md

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.