

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-024726

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 281

STATE FILE NUMBER

**FILED JUN 20 1963**

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>INDEPENDENCE</b>		c. CITY OR TOWN <b>INDEPENDENCE</b>	
Length of stay in 1b <b>20 yrs.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>INDEP. SAN. &amp; HOSP.</b>		d. STREET ADDRESS (if outside, give location) <b>11228 EAST 39th St.</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>MARVIN</b> Middle <b>C.</b> Last <b>GALLOP</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>16</b> Year <b>1963</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-23-1912</b>	9. AGE (last birthday) <b>50</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHEFFIELD STEEL CORP.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL INDUSTRY</b>		11. BIRTHPLACE (City and state or country) <b>PARIS, MISSOURI</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>DAVID GALLOP</b>		13b. MOTHER'S MAIDEN NAME <b>SARAH ANDERSON</b>	
14. NAME OF HUSBAND OR WIFE <b>RUBY M. GALLOP</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <b>NO NO</b>			
16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT Address <b>Ruby M. Gallop, 11228 E. 39th St., Indep. Mo.</b>			

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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

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. Month, Day, Year _____	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 _____

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Duquesne Owens Coroner</b>		22b. ADDRESS <b>Corner 152 Union Station</b>		22c. DATE SIGNED <b>6-17-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>6-18-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEMETERY</b>	23d. LOCATION (City, town, or county) <b>INDEPENDENCE, MISSOURI</b>	
24. FUNERAL DIRECTOR ADDRESS <b>GEO. C. CARSON &amp; SONS, INDEPENDENCE, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>6-18-63</b>	26. REGISTRAR'S SIGNATURE <b>Alba L. Gray</b>	

DO NOT WRITE ON THIS STUB  
 AMENDED  
 VS 300 Rev. 4/59  
 1 7005  
 2 7005  
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 4 0  
 5 1  
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 7 0  
 8 2  
 9 420.1  
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 12 1-3  
 13 1-0  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF  
 USE BLACK INK OR TYPEWRITER RIBBON

JUN 25 1963

MAR 16 1964

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4-18-64

8-1

**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 Marshall G. Blackwell

Licensed Embalmer No. 4713

P. O. Address Kansas City, 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.