WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Jasper

Township Joplin

or Village

or City Webb City (NO. ____ St.; ____ Ward)

Registration District No. 417 File No. 26759

Primary Registration District No. 3021 Registered No. 174

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Charley Payne Gallienne

PERSONAL AND STATISTICAL PARTICULARS

SEX Male | COLOR OR RACE White | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH November (Month) 8 (Day), 1850 (Year)

AGE 67 yrs. 9 mos. 23 ds. | If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Police Judge
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Gurnsey England

PARENTS
NAME OF FATHER John M. Gallienne
BIRTHPLACE OF FATHER (City or town, State or foreign country) England
MAIDEN NAME OF MOTHER Judith Payne
BIRTHPLACE OF MOTHER (City or town, State or foreign country) N Jersey

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Webb City Und Co

(ADDRESS) 114 E. Daugherty St

Filed Sept. 3d, 1918. C. E. McBride REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 31th (Month) (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from 7-1-, 1917, to 8-31, 1918, that I last saw him alive on 8-31, 1918, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows: Chronic nephritis

131 120 (Duration) 2 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) ___ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) H. S. Rateff M. D.

8-2, 1918 (Address) Webb City Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Mt Hope Cem | DATE OF BURIAL Sept 3, 1918

UNDERTAKER W. S. K. Mills | ADDRESS Webb City

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1_____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 191____
UNDERTAKER	**ADDRESS**