

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

Do not use this space.

4889

**1. PLACE OF DEATH**

County Saline  
Township Marshall  
City Marshall (No. ....)

Registration District No. 796  
Primary Registration District No. 3039

File No. ....  
Registered No. 2  
St. .... Ward

**2. FULL NAME**

Hugh J. Galbraith  
(a) Residence. No. 101 State school St. .... Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 8 mos. 25 ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ____ hrs. or ____ min.
	<u>44</u>	<u>7</u>	<u>27</u>	
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work <u>None</u>				
(b) General nature of industry, business, or establishment in which employed (or employer) _____				
(c) Name of employer _____				

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 2 1929

17. I HEREBY CERTIFY, That I attended deceased from March 5, 1928, to Jan 2, 1929 that I last saw him alive on Jan 1, 1929, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Bronchopneumonia  
11 M  
107 H (duration) ..... yrs. .... mos. .... ds.  
CONTRIBUTORY Defauniga (SECONDARY) (duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
NOT AT PLACE OF DEATH  
DID AN OPERATION PRECEDE DEATH? NO DATE OF .....  
WAS THERE AN AUTOPSY? NO  
WHAT TEST CONFIRMED DIAGNOSIS Clinical  
(Signed) H. H. Cooper M. D.  
12, 1929 (Address) Marshall Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Newton Co. Mo

10. NAME OF FATHER J. H. Galbraith

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Hospital Record  
(Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Neosho Mo. DATE OF BURIAL 1-4 1929

15. FILED 1-8, 1929 Mrs. John H. M. Quinn REGISTRAR

20. UNDERTAKER Sweeney ADDRESS Marshall

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.

26

33

3



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County Saline Registration District No. 796 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 2038 Registered No. 2  
 City Marshall (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Hugh G. Galbraith  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-6-1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
44 7 27

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_ (duration) yrs. mos. ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

14.

INFORMANT \_\_\_\_\_  
 (Address) \_\_\_\_\_

15.

FILED 1-8-29 Mrs. John H. McKinnis  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 2 1929

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_ that I last saw him \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH: \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

19

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. REGIS. RARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-4259