1512
H Campbell

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

Do not use this space.

File No. 40373
Registered No. 934

1. PLACE OF DEATH
County Greene
Township Campbell
City ~~Springfield~~ (No. R.F.D. #9 St. Ward)
Registration District No. Dr Bates
Primary Registration District No. 5440

2. FULL NAME J. D. Galbraith
(a) Residence. No. R.F.D. #9 St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) |
|---|---|---|
| m | w | married |

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Josephine Christian

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 23-1859

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 69 | 11 | 27 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(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) Tenn.

PARENTS
10. NAME OF FATHER Condor Galbraith
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn.
12. MAIDEN NAME OF MOTHER Dorcella Drumright
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

14. INFORMANT Mrs J. D. Galbraith
(Address) R.F.D. #9

15. FILED 12/22, 1929 Lon Sharp REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-20 1929

17. I HEREBY CERTIFY, That I attended deceased from 12/14, 1929, to 12-20, 1929 that I last saw h— alive on 12-15, 1929, and that death occurred, on the date stated above, at 10 30 am m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Dis of Heart 92B
Chronic valvular endocarditis
(duration) one yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. G. Cakevan, M. D
12/20, 1929 (Address) Springfield 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cast Lawn
DATE OF BURIAL 12-22 29 1929

20. UNDERTAKER W. L. Warren
ADDRESS Walnut Mo

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.

JAN 10 1929

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