

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

Do not use this space.

21389

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis* (No.....)

Registration District No. *791*
Primary Registration District No. *1003*

File No. ~~01191~~
Registered No. *6264*
St. *24* Ward

2. FULL NAME *William E. Galloway*

(a) Residence No. *1622 Mississippi 23* Ward.....
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *3* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* | 4. COLOR OR RACE *White* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 25 1930*

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

17. I HEREBY CERTIFY, That I attended deceased from *6-23*, 19*30*, to *6-25*, 19*30*, that I last saw him alive on *6-25*, 19*30*, and that death occurred, on the date stated above, at *6:15* p.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *7-6-1917*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
|--------|-----------|-----------|-----------|--|
| | <i>12</i> | <i>11</i> | <i>19</i> | |

Brain abscess cause unknown
791

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *School*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

CONTRIBUTORY (SECONDARY) *700*
(duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ill*

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH

10. NAME OF FATHER *Wm Galloway*

18. DID AN OPERATION PRECEDE DEATH? *5* DATE OF
WAS THERE AN AUTOPSY? *yes*

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

WHAT TEST CONFIRMED DIAGNOSIS? *autopsy*
(Signed) *R. K. ...*, M. D.

12. MAIDEN NAME OF MOTHER *Josie Duncan*

6-26, 19*30* (Address) *ISOLATION HOSPITAL*

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

*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.

14. INFORMANT (Address) *ISOLATION HOSPITAL*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
St Mathews Cemetery 6-28 1930

15. FILED *1930* REGISTRAR *McLaughlin*

20. UNDERTAKER ADDRESS
McLaughlin - 163/100 Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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