

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

Do not use this space.

26137B 2  
89  
St. \_\_\_\_\_ Ward \_\_\_\_\_

NOV 24 1930

26537-2

1. PLACE OF DEATH  
Howell

County \_\_\_\_\_

Registration District No. 3821

Township Howell

Primary Registration District No. 4227

City West Plains, Mo. (No. \_\_\_\_\_)

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

2. FULL NAME Sarah Elizabeth Galloway.

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

(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 Female  
4. COLOR OR RACE White  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 10, 1860

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
70	1	17	

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

10. NAME OF FATHER John Vickers

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT W. C. Galloway (Address) West Plains, Mo.

15. FILED 8-30-30 O. A. Heunich REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 27th, 1930

17. I HEREBY CERTIFY, That I attended deceased from July 23rd, 1930 to Aug. 27th, 1930 that I last saw her alive on Aug. 24th, 1930, and that death occurred, on the date stated above, at 4:00 P. M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Carcinoma in pelvis, involving descending colon and sigmoid flexure.

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

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

0 DID AN OPERATION PRECEDE DEATH? no. DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical (Signed) A. H. Thornburgh, M. D.

8/28, 1930 (Address) West Plains, 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 Mt. Zion Cemetery DATE OF BURIAL 8/28/30,

20. UNDERTAKER Hal Thornburgh ADDRESS West Plains 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.

