

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

Do not use this space.

**1. PLACE OF DEATH**

County Webster  
Township Seymour  
City Seymour (No.         )

Registration District No. 897  
Primary Registration District No. 4543

File No. 28977  
Registered No. 25  
St.          Ward         

**2. FULL NAME**

(a) Residence. No. Lula May Gallion 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 12, 1930

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

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work none  
(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) Mo

**PARENTS**  
10. NAME OF FATHER Virgel Gallion  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Okla.  
12. MAIDEN NAME OF MOTHER May F. Liles  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

14. INFORMANT Virgil Gallion  
(Address) Seymour, Mo

15. FILED 8/4 1930 L. A. Watson REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 4 1930

17. I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to Aug 4, 1930 that I last saw him alive on Aug 3, 1930, and that death occurred, on the date stated above, at 1 A m.

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

16:1 B  
Acute Hepatitis  
Stenocardia  
(duration) yrs. mos. ds.           
CONTRIBUTORY (SECONDARY) 12/4 B  
(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) Paul D. Upshaw, M.D., M. D.  
8/4 1930 (Address) Seymour, 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          DATE OF BURIAL 8/4 1930

20. UNDERTAKER          ADDRESS         

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.

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