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.

APR 25 1934

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

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 10827

Township ..... Primary Registration District No. 1003 Registered No. 2673

City St. Louis Mo (No. Barnes Hospital St. ..... Ward)

2. FULL NAME Gail Marceline Galloway

(a) Residence, No. 5249 Bonita St., 7 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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 F

4. COLOR OR RACE W.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 1 - 1912

7. AGE YEARS 22 MONTHS 2 DAYS 14 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation 3

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) O'Fallon Ill.

FATHER

13. NAME Thomas E. Greiner

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) O'Fallon Ill.

MOTHER

15. MAIDEN NAME Iva Puffer

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

17. INFORMANT (ADDRESS) James C. Galloway O'Fallon Ill

18. BURIAL, CREMATION, OR REMOVAL PLACE O'Fallon Ill DATE 3-17- 1934

19. UNDERTAKER (ADDRESS) Albert H. Happe Inc 4297 Euclid Ave

20. FILED MAR 10 1934 19 J. F. Bredick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3 - 15 - 1934

22. I HEREBY CERTIFY, That I attended deceased from 3 - 13 - 1934, to 3 - 15 - 1934

I last saw her alive on 3 - 15 - 1934. Death is said to have occurred on the date stated above, at 2:55 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Rheumatic heart disease	1925
Cerebral hemorrhage	2-1-34
Bronchial pneumonia	3-13-34

95C
91A
82A

Other contributory causes of importance:
Subacute bacterial endocarditis

95 61

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) C. M. Charles, M. D.

(Address) Barnes Hospital

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