

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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

4668
 Do not use this space.

REC'D MAR 14 1938

1. PLACE OF DEATH **Homer G Phillips Hospital**

(a) County..... Registration District No. **791**
 (b) Township..... Primary Registration District No. **1003** Registered No. **1313**
 (c) City **St. Louis** (d) Street No. **2601** **N. Whittier** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred **45** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **James Galloway 400**

(a) Residence, No. **Star Hotel - Jefferson and Pine** St. **21** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M	4. COLOR OR RACE C	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Separated	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Gertrude Galloway			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 10, 1877			
7. AGE YEARS 60	MONTHS 4	DAYS 19	If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. nil		11. Total time (years) spent in this occupation.....	
9. Industry or business in which work was done, as saw mill, bank, etc.		10. Date deceased last worked at this occupation (month and year).....	

12. BIRTHPLACE (CITY OR TOWN) **Canton**
 (STATE OR COUNTRY) **Mississippi**

FATHER
 13. NAME **George Galloway**
 14. BIRTHPLACE (CITY OR TOWN) **unknown**
 (STATE OR COUNTRY)

MOTHER
 15. MAIDEN NAME **Lucy ?**
 16. BIRTHPLACE (CITY OR TOWN) **unknown**
 (STATE OR COUNTRY)

17. INFORMANT **Evelyn Hilliard**
 (ADDRESS) **2601 N Whittier**

18. BURIAL, CREMATION, OR REMOVAL
 PLACE **Greenwood** DATE **2/5** 1938

19. FUNERAL DIRECTOR **A. Russell**
 (ADDRESS) **2782 Pine Blvd.**

20. FILE **FEB 5 1938**
J. Bredek Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan. 29** 1938

22. I HEREBY CERTIFY, That I attended deceased from **Oct. 18**, 1937, to **Jan. 29**, 1938

I last saw him alive on **Jan. 29**, 1938 Death is said to have occurred on the date stated above, at **11:35** a. m.

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

Arteriosclerotic heart disease Date of onset **10/18/37**

Other contributory causes of importance:
Thrombosis with left popliteal artery
Amputation of left thigh, caused by gangrene, gangrene caused by thrombosis of left popliteal artery
 Name of operation..... Date of **1/17/37**
 What test confirmed diagnosis: **clinical** Was there an autopsy? **NO**

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) **[Signature]** M. D.
 (Address) **Homer G Phillips Hospital**

NOV 5 1947

OCT 3 1947

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. 2115

hereby certify that the body recorded on the reverse side of this certificate was embalmed by *me*

L. E.

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed *Joel Russell*

Licensed Embalmer No. 2115

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)