

REC'D APR 17 1939

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

9398
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Rain Primary Registration District No. 1092 Registered No. 1004
(c) City Kansas City (d) Street No. Research Hospital 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 450 yrs. mos. ds. (f) How long in U. S., if of foreign birth? 450 yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Mansburg # 3 St. (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 wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Saldie Galyon
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Febr. 16 1878
7. AGE YEARS 60 MONTHS 5 DAYS 17 If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Driller
9. Industry or business in which work was done, as saw mill, bank, etc. (Coar)
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

FATHER 13. NAME John J Galyon

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

MOTHER 15. MAIDEN NAME Sarah Morgan

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

17. INFORMANT (NAME) Mr. Saldie Galyon
(ADDRESS) Warrsburg info

18. BURIAL, CREMATION, OR REMOVAL PLACE West Hill DATE 3/7 39

19. FUNERAL DIRECTOR (NAME) Mr. Ch. Foster
(ADDRESS) 918 Brooklyn H. C. Mo

20. FILED 3/6 1939 M. M. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 3 1939

22. I HEREBY CERTIFY That I attended deceased from February 26 1939 to March 3 1939
I last saw him alive on March 3 1939. Death is said to have occurred on the date stated above, at 1:50 p.m.

The principal cause of death and related causes of importance were as follows:
Left Lobar Pneumonia
Type III
Date of onset 2/25-39
108

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Post 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) John J. Laph M. D.
(Address) 1314 Professional Bldg

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.

1314
1230
219335
PL-5741
12/30/11
11/2/11

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.