

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.

JUN 21 1939

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

19074
 Do not use this space.

1. PLACE OF DEATH *Lawrence*

(a) County *GREENE* Registration District No. *474 376*

(b) Township *Oparka* Primary Registration District No. *3698* Registered No. _____

(c) City *Lawrence, Mo. Rd.* (d) Street No. *Route 1 Mt Vernon, Mo.* St. _____

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *JAMES Gallagher*

(a) Residence, No. *211 Mt Vernon, Mo.* St. _____ (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 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) *ANNA GALLAGHER*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>71</i>	<i>3</i>	<i>20</i>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Farmer*

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) _____

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tennessee*

FATHER

13. NAME *Unknown*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *unknown*

MOTHER

15. MAIDEN NAME *Mary C Cheek*

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

17. INFORMANT *Mr. Glenn Cox*
(ADDRESS) *2450 W. Robertson*

18. BURIAL, CREMATION, OR REMOVAL
PLACE *Green Valley* DATE *5/25/39*

19. FUNERAL DIRECTOR (NAME) *Dunn-Hall*
(ADDRESS) *629 W. Walnut*

20. FILED *5/24* - 19 *39* *Mrs. Anna Wilkinson*
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 23* 19 *39*

22. I HEREBY CERTIFY, That I attended deceased from *Feb. 21* 19 *39*, to *May 17* 19 *39*

I last saw him alive on *May 17* 19 *39*. Death is said to have occurred on the date stated above, at *5 P.* m.

The principal cause of death and related causes of importance were as follows:
Gastric Cancerous
date of onset not known

Date of onset _____

Other contributory causes of importance: *46*
Inherited defect

Name of operation *none* Date of _____

What test confirmed diagnosis *Lab. test* 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? *no*

If so, specify _____

(Signed) *L. J. Palmer* M. D.
 (Address) *Wills mo*

RECEIVED

District Health Officer No. 6,

District File Number 6-6-39-1187

Date Filed JUN 7 1939

Anna Miller, M.D.

JAN 29 1937

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 *Harold W. Joffe*
Licensed Embalmer No. 2910
P. O. Address 629 W Walnut

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

19074
Do not use this space.

1. PLACE OF DEATH
 (a) County Laclede Registration District No. 474
 (b) Township Clark Primary Registration District No. 5638
 (c) City St. Louis (d) Street No. _____ St.
 (II 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 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James Gallagher
 (a) Residence, No. _____ 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 w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 9, 1871

7. AGE YEARS 71 MONTHS 3 DAYS 20 If LESS than 1 day, _____ hrs. or _____ min.

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

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

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

FATHER 13. NAME Unknown

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Mary C. G. ...

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Mrs. ... 2450 N. ...

18. BURIAL, CREMATION, OR REMOVAL PLACE ... Lawn DATE 5-25- 1939

19. FUNERAL DIRECTOR (ADDRESS) ... - April 629 W. Walnut Springfield Mo

20. FILED 5/24 1939 Mrs. Anna ... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-23 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 21 1939 to May 17 1939
 I last saw him alive on May 17 1939. Death is said to have occurred on the date stated above, at 2 P. m.
 The principal cause of death and related causes of importance were as follows:
Gastric Carcinoma
Date of onset Unknown
 Other contributory causes of importance:
Interstitial Nephritis
 Name of operation none Date of _____
 What test confirmed diagnosis? lab. test 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? no
 If so, specify _____
 (Signed) R. J. Holmes M. D.
 (Address) ... Miller

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 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.

