

MAY 15 1940

Registration District No. 384

Primary Registration District No. 4227

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Howell
 (b) City or town West Plains Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 Months (Specify whether years, months or days)

3. (a) PRINT FULL NAME Robert H Galloway

3. (b) If veteran, name war V 3. (c) Social Security No. 400

4. Sex Male 5. Color or race W 6. (a) Single, Single, married, divorced

6. (b) Name of husband or wife V 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Jan (Month) 10 (Day) 1907 (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>33</u>	<u>3</u>		hr. _____ min.

9. Birthplace Oregon (City, town, or county) (State or foreign country)

10. Usual occupation Journelem

11. Industry or business _____

12. Name Robert Galloway

18. Birthplace Penn. (City, town, or county) (State or foreign country)

14. Maiden name Sarah Heaton

15. Birthplace Ill. (City, town, or county) (State or foreign country)

16. (a) Informant Sarah Heaton

(b) Address West Plains Mo.

17. (a) West Plains Mo. (b) Date thereof April 14-40 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Plains Mo.

18. (a) Signature of funeral director John J. Amoss

(b) Address West Plains Mo.

19. (a) 4-13-40 (b) Uida W. SIMONS (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Howell
 (c) City or town West Plains Mo.
(If outside city or town limits, write "RURAL")
 (d) Street No. College st
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10th year 1940 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from 4/8 1940 to 4/10 1940, that I last saw him alive on 4/10 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 3 days

Due to _____

Due to _____

Other conditions 198 (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 344

While at work? _____ (Specify type of place) (e) Means of injury A

23. Signature Maurice Thompson (M. D. or other) MD

Address West Plains Mo. Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.

RECEIVED
working under my personal supervision.

District Health Officer No. 5,

District File Number 540 535

Date Filed 51040

Signed John J. Amman

Licensed Embalmer No. 2516

P. O. Address Man View Gmo

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.