

2
3-40
7-39
X23159

Registration District No. 944 Primary Registration District No. 5438

1. PLACE OF DEATH
(a) County GREENE
(b) City or town Rural
(c) Name of hospital or institution: Route # 2 Springfield, Mo.
(d) Length of stay: In hospital or institution 2
In this community 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Rural
(d) Street No. Route # 2 Springfield, Mo.
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME Mark P. Galbraith
(b) If veteran, name war no
(c) Social Security No. no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 23
year 1940 hour 8 minute 15 p. M.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

21. I hereby certify that I attended the deceased from Sept. 8, 1940 to Sept. 23, 1940
that I last saw him alive on Sept. 23, 1940
and that death occurred on the date and hour stated above.

7. Birth date of deceased Sept. 13 1870
8. AGE: Years 70 Months 0 Days 10

Immediate cause of death Chronic Nephritis
Arterial Sclerosis
Duration 2 1

9. Birthplace Greene County Missouri
10. Usual occupation Farmer

Other conditions
Major findings: Of operations No
Of autopsy No

11. Industry or business
12. Name Stephen D. Galbraith
13. Birthplace Tennessee
14. Maiden name Elizabeth Hagan
15. Birthplace Tennessee

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Tom Galbraith
(b) Address Route # 2, Springfield, Mo.
17. (a) Burial (b) Date thereof Sept. 25 1940
(c) Place: burial or cremation Galbraith Cem.
18. (a) Signature of funeral director H. H. Lohmeyer
(b) Address Springfield, Mo.
19. (a) 9-26-40 (b) Harry Grier

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
23. Signature Dr. Focht (M. D. or other)
Address Springfield Mo Date signed 9/26/40

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

RECEIVED

Greene County Health Office,

County File Number 40-10-79

Date Filed 10/10/40

Sept 26

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 *M. L. Canaday*

Licensed Embalmer No. 3424

P. O. Address *Springfield, Mo.*

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

If this body is not embalmed, fact should be so stated above.