No. 2
1-4-41
17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 18 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35324

Registration District No. 6 4 4 5

Primary Registration District No. 4409

Registrar's No. 19

1. PLACE OF DEATH:
(a) County: Pike
(b) City or town: Clarksville Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Pike 82
(c) City or town: Clarksville 9
(If outside city or town limits, write "RURAL")
(d) Street No. .....
(If rural, give location)
(e) Citizen of foreign country? U (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Bennis Ray Galbreth
3. (b) If veteran, name war: World War
3. (c) Social Security No. .....
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Nadine Galbreath
6. (c) Age of husband or wife if alive: 48 years
7. Birth date of deceased: January (Month) 12 (Day) 1894 (Year)

8. AGE: Years	Months	Days	If less than one day
49	9	8	hr. ..... min.

9. Birthplace: Audrain Co Mo (City, town, or county) (State or foreign country)
10. Usual occupation: Merchant
11. Industry or business: Drugist
FATHER
12. Name: Robert Lee Galbreath
13. Birthplace: Moberly Mo U (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Marion Owings
15. Birthplace: Moberly Mo U (City, town, or county) (State or foreign country)
16. (a) Informant: Nadine Galbreath
(b) Address: Clarksville
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof: Oct 22/41 (Month) (Day) (Year)
(c) Place: burial or cremation: Greenwood
18. (a) Signature of funeral director: Harry Carroll
(b) Address: Clarksville Mo
19. (a) 11-4-41 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 19 day
year 1941 hour about 6 minute a M.
21. I hereby certify that I attended the deceased from ....., 19..., to ....., 19...;
that I last saw h..... alive on ....., 19...;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Suicide By drinking Carbolic Acid	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

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

22. If death was due to external causes, fill in the following: V
(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? ..... (Specify type of place)
While at work? ..... (e) Means of injury 3
23. Signature: M. L. Smith Coroner (M. D.)
Address: Louisiana, Mo. Date signed 10/29/41

(Licensed Embalmer's Statement on Reverse Side)

MAR 29 1945

DEC 12 1941

RECEIVED
District Health Officer No. 10
District File Number 11-41-2035
Date Filed NOV 13 1941

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

Signed Harry L. Harrold

Licensed Embalmer No. 2439

P. O. Address Clarksville Mo

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, fact should be so stated above.

V. S. No. 2B
0M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35774

Registration District No. 685 Primary Registration District No. 4409 Registrar's No.

1. PLACE OF DEATH:

(a) County Pike

(b) City or town Clarksville (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Dennis R. Colbreth

3. (b) If veteran, name war W-W-

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased Jan. 12, 189 (Month) (Day) (Year)

8. AGE: Years 49 Months 9 Days 8 If less than one day hr. min.

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

10. Usual occupation Merchant

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death Suicide by drinking Carbolic acid

Due to

Due to Ill Health

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

1637

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

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

(b) Date of occurrence Oct 20th 1941

(c) Where did injury occur? Clarksville (City or town) Pike (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Her Drug Store (Specify type of place)

While at work? Her (e) Means of injury Burn from Carbolic

23. Signature Colbreth Connor (M. D. or other)

Address Louisiana, Mo Date signed 10/20/41

FEB 6 1942

S-35774