DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

14854

State File No.

FILED MAY 23 1942

Registration District No. 3028

Primary Registration District No. 3026

Registrar's No. 67

1. PLACE OF DEATH:

(a) County: Livingston

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

(c) Name of hospital or institution: 86 Walnut St.
(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: Missouri (b) County: Livingston

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

(d) Street No.: 86 Walnut St.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME: Maude Galvin

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: John R. Galvin

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

7. Birth date of deceased: April (Month) 4 (Day) 1865 (Year)

8. AGE: Years 77 Months 0 Days 19 If less than one day — hr. — min.

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

10. Usual occupation: Housewife

11. Industry or business: —

FATHER

12. Name: Livingston Gibbons

13. Birthplace: Unknown (City, town, or county) — (State or foreign country)

MOTHER

14. Maiden name: Sarah J. Alley

15. Birthplace: Unknown (City, town, or county) Ohio (State or foreign country)

16. (a) Informant: Burt Luter Molloy

(b) Address: Chillicothe, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-25-42 (Month) (Day) (Year)

(c) Place: burial or cremation: Edgewood Cem.

18. (a) Signature of funeral director: James D. Gordon

(b) Address: Chillicothe Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23 year 1942 hour 9 minute 45 A.M.

21. I hereby certify that I attended the deceased from September, 1941, to April 23, 1942, that I last saw her alive on April 22, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma, Metastasis to lungs

Due to:

Due to:

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.

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: W. D. Landrum (M. D. or other)

Address: Chillicothe Mo. Date signed 4-24-42

(Licensed Embalmer's Statement on Reverse Side)

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 Donald F. Gordan

Licensed Embalmer No. 4191

P. O. Address Gillicothe, T

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

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

V. S. No. 2B
10M—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. 14825-4

Registration District No. 5-88 Primary Registration District No. 3026 Registrar's No.

1. PLACE OF DEATH:
(a) County: Livingston
(b) City or town: Chillicothe
(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: Livingston
(c) City or town: Chillicothe
(If outside city or town limits, write "RURAL")
(d) Street No.: 86 Walnut St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Maude Galvin
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
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) April 24-1942 (Date received local registrar) (b) Lou Ella Curry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23 year 1942 hour 9 minute 45a M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma, metastasis to lungs	
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:
(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
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY