

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4197
Registrar's No. 1727

FILED MAR 2 1943

Registration District No. _____ Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
Bethesda Hospital
(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 _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Clarence Galt

3. (b) If veteran, name war _____ 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 Minnie Galt 6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased 4 17 1902
(Month) (Day) (Year)

8. AGE: Years 40 Months 10 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Arthur F. Galt

{ 13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

{ 14. Maiden name Bessie Glat Snyder

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

16. (a) Informant Minnie Galt

(b) Address _____

17. (a) Burial (b) Date thereof 2/23/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. James Missouri

18. (a) Signature of funeral director Albert H. Hoppe Inc

(b) Address 4700 Washington Blvd.

19. (a) FEB 24 1943 (b) J. J. Bredick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps

(c) City or town St James
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 21
year 1943 hour 4 minute 30 M.

21. I hereby certify that I attended the deceased from Feb 20 to Feb 21 1943
that I last saw him alive on Feb 20 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction
Duration 5

Due to _____

Due to _____

Other conditions Bronchial Asthma?
(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? _____

While at work _____ (e) Means of injury _____

23. Signature J. J. Bredick (M. D. or other) MD
Address 4700 Olive Date signed 2-21-43

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.....

J. W. Wilkins

Licensed Embalmer No.....

3575

P. O. Address.....

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.