

FILED MAY 12 1943

318

1003

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... **St. Louis,**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1740 S. 18th St.
(If out in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... **54 years** (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County.....
(c) City or town..... **St. Louis,**
(If outside city or town limits, write "RURAL")
(d) Street No. **1740 S. 18 Str.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country..... **0**

3. (a) PRINT FULL NAME **Robert F. Gallo**

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

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

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

7. Birth date of deceased **Unknown about 1889**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 54 Unknown hr. min.

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

10. Usual occupation **Roofer**
11. Industry or business **Buildings**

12. Name **Robert F. Gallo**
13. Birthplace **Germany** 4
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Storck**
15. Birthplace **Germany** 4
(City, town, or county) (State or foreign country)

16. (a) Informant **B. L. Shantz**
(b) Address **1740 S. 18 Str.**

17. (a) **Cremation** (b) Date thereof **5/4/43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Missouri crematory**

18. (a) Signature of funeral director **Wm. E. Moydell**
(b) Address **1926 Allen Ave.**

19. (a) **MAY 2 1943** (b) **J. F. Brudick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **8** year **1943** hour..... minute **35** 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.

Immediate cause of death.....
Coronary Occlusion
Coronary Sclerosis
Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

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

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?

While at work?..... (Specify type of place) (e) Means of injury.....
23. Signature **Thomas F. Calloway** (M.D. or other)
Address **Deputy Coroner** Date signed **5-7-43**

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

Signed Wm. E. Moyzell
Licensed Embalmer No. 1467
P. O. Address. # 1926 Allen av

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.