

FILED NOV 1 1943 149

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 4245

1. PLACE OF DEATH: Jackson
 (a) County: Jackson
 (b) City or town: Kansas City
 (c) Name of hospital or institution: St. Lukes Hospital
 (d) Length of stay: In hospital or institution: 3 days
 In this community: 3 days

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Mo. (b) County: Jackson
 (c) City or town: Triplett Mo.
 (d) Street No.: _____
 (e) Citizen of foreign country? (Yes or No)

3. (a) PRINT FULL NAME: GALLATIN, JOHN Russell

MEDICAL CERTIFICATION

3. (b) If veteran, name war: no
 3. (c) Social Security No.: none

20. DATE OF DEATH: Month 10 day 6 year 43 hour 5:55 min AM

4. Sex: M Color of hair: B Race: W
 5. Color of eyes: B
 6. (a) Single, widowed, married, divorced, child

21. I hereby certify that I attended the deceased from _____ 19____
 that I last saw him alive on _____ 19____
 and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife: _____
 6. (c) Age of husband or wife if alive: _____ years
 7. Birth date of deceased: Oct 17 1931

Immediate cause of death: Sept. fractured humerus
 Laceration of the hand

8. AGE: 11 Years 11 Months 24 Days

Due to: Contusion of the head

9. Birthplace: Triplett Mo. Child

Due to: Struck by motor car

10. Usual occupation: Child

Other conditions: (Include pregnancy within 3 months of death)

11. Industry or business: _____

Major findings: Of operations: _____

12. Name: Geop. Gallatin
 13. Birthplace: Triplett Mo.
 14. Maiden name: Lettie M. Marshall
 15. Birthplace: Glenwood

Of autopsy: Specimen 1100 21

16. (a) Informant: G. R. Gallatin
 (b) Address: Triplett Mo.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify): Accident 1.2.1

17. (a) Date: 10-8-43
 (b) Date thereof: 10-8-43

(b) Date of occurrence: 10/5/43
 (c) Where did injury occur?: Highway

(c) Place: burial or cremation: Triplett Mo.

(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: 10/6/43

18. (a) Signature of funeral director: _____
 (b) Address: _____

23. Signature: _____ (M. O. number) 3

19. (a) 10-6-43 (b) T. E. Brown

Address: _____ Date signed: _____

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Licensed Embalmer No.....

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.