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DOM-2.43  
5-17-39  
-I X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8005

State File No. \_\_\_\_\_

FILED MAR 14 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 3054

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Pike

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

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

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

In this community 17 years

3. (a) PRINT FULL NAME Edith Galloway

3. (b) If veteran, name war no

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: Dec 21 1900  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>43</u>	<u>2</u>	<u>6</u>	_____ hr. _____ min.

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

10. Usual occupation Hotel Clerk

11. Industry or business at Hotel

MOTHER FATHER

12. Name Edith Galloway

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

14. Maiden name Berta Cobb

15. Birthplace New Hope Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Edith Galloway

(b) Address M.O.

17. (a) Cremation (b) Date thereof Feb. 29, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis M.O.

18. (a) Signature of funeral director Warner + Stone

(b) Address Louisiana M.O.

19. (a) 2-29-44 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike

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

(d) Street No. 306 1/2 Morgan  
(If rural give location)

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

If yes, name country L

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27 year 1944 hour 7:45 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from 12-13-41 to 2-27-44 19\_\_\_\_

that I last saw her alive on 2-26-44 19\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Metastatic Carcinoma

Due to Carcinoma of ovary

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

Major findings: Carcinoma of ovary

Of operations \_\_\_\_\_

Of autopsy none

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 none

(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 [Signature] (M. D. or D. O.)

Address Louisiana M.O. Date signed 2-29-44

3-20-8

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RECEIVED

District Health Officer No. 10

District File Number 3-44-501

Date Filed MAR 8 1944

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, only

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed J. B. Atterme

Licensed Embalmer No. 4039

P. O. Address Louisiana, 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.

*[Handwritten signature/initials]*