

FILED MAR 24 1945

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

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

Registration District No. 276

Primary Registration District No. 5946

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

1. PLACE OF DEATH:

(a) County Phelps  
 (b) City or town Cook Station Rural  
 (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 \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps  
 (c) City or town Cook Station Rural  
 (If outside city or town limits, write "RURAL") \_\_\_\_\_  
 (d) Street No. \_\_\_\_\_  
 (If rural, give location) \_\_\_\_\_  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

3. (a) PRINT FULL NAME Arthur F Galt

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

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

6. (b) Name of husband or wife Bessie Galt 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased 7-8-1878  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>5</u>	<u>9</u>	hr. _____ min.

9. Birthplace Petersburg Ill  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Elyah L Galt

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

14. Maiden name Mary Berger

15. Birthplace Ill  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bessie Galt

(b) Address Cook Station Mo

17. (a) Removal (b) Date thereof 7-18-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Louis

18. (a) Signature of funeral director W. Schickler

(b) Address St James 3101

19. (a) 12-18-1944 (b) J. Chamiektion  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 17  
year 1944 hour 12-50 minute P M.

21. I hereby certify that I attended the deceased from June, 1944 to Dec 17, 1944  
that I last saw him alive on Dec 16, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Embolus  
Due to Cerebral Hemorrhage

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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 William Brewer (M. D. or other) \_\_\_\_\_  
Address St James Mo Date signed \_\_\_\_\_

Duration 2 day

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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 W E Licklider

Licensed Embalmer No. 1970

P. O. Address St James 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, above space should be left blank.**