V. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 4 1945

Registration District No. 7

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13330

Primary Registration District No. 5434

Registrar's No. 41

36
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1. PLACE OF DEATH:

(a) County: Franklin.

(b) City or town: Washington. "Rural" St. John's.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R.F.D. #1.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: None. (Specify whether years, months or days)

In this community: 76 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Franklin

(c) City or town: Washington "Rural"
(If outside city or town limits, write "RURAL")

(d) Street No.: R.F.D. #1.
(If rural, give location)

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

If yes, name country: X

3. (a) PRINT FULL NAME: Mary Ellen Galbraith.

3. (b) If veteran, name war: X

3. (c) Social Security No.: X

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband: Robert Galbraith.

6. (c) Age of husband: alive deceased years

7. Birth date of deceased: Sept. (Month) 21st. (Day) 1868. (Year)

8. AGE: Years 76 Months 6 Days 13 If less than one day ___ hr. ___ min.

9. Birthplace: Newport, Franklin Co. (City, town, or county) Missouri. (State or foreign country)

10. Usual occupation: Housework.

11. Industry or business: X

MOTHER FATHER

12. Name: Samuel S. Bailey.

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

14. Maiden name: Mary Fatton.

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

16. (a) Informant: R. Farris Galbraith.

(b) Address: Washington, Mo. R.F.D. #1.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Apr. 7, 1945. (Month) (Day) (Year)

(c) Place: burial or cremation: Washington, Mo. R.F.D. #1.

18. (a) Signature of funeral director: Nilburg & Pitt, Inc.

(b) Address: Washington, Mo.

19. (a) 4/6/45 (Date received local registrar) (b) Lucile R. Brooks (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4th. year 1945 hour 10:00 minute 45 P.M.

21. I hereby certify that I attended the deceased from March 24, 1945 to April 3, 1945 and that I last saw her alive on April 2, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Apoplexy	2 hrs.
Due to: Arteriosclerosis with hypertension	Don't know
Due to:	
Other conditions (Include pregnancy within 3 months of death): Auricular fibrillation	3 yrs.

Major findings:
Of operations: no operation
Of autopsy: no 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: B. Eisenmann (M. D. or other) MD.

Address: New Haven, Mo. Date signed 4/6/45.

1181

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 5-3-45

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 A. C. Nieburg

Licensed Embalmer No. 2387

P. O. Address Washington 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.