S. No. 2
-11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

41818

FILED JAN 5 1946

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 364

1. PLACE OF DEATH:

(a) County MARION

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

(c) Name of hospital ~~or institution~~ Levering Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 ds (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Audrain 4

(c) City or town R 2 Vandalia Mo 0
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME KATIE Galloway

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 1

5. Color or race W

6. (a) ~~Single, widowed,~~ married, ~~divorced~~ MARRIED 1

6. (b) Name of husband or wife J. E. GALLOWAY.

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased DEC- 6- 1866.
(Month) (Day) (Year)

8. AGE: Years 78 Months 11 Days 27. If less than one day hr. min.

9. Birthplace STOCKWELL, INDIANA 1
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE.

11. Industry or business HOME.

FATHER
12. Name HENRY-D-LAFEVER. 7
13. Birthplace UNKNOWN. 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name CATHERINE-DONALDSON
15. Birthplace COLUMBUS OHIO. 1
(City, town, or county) (State or foreign country)

16. (a) Informant J. E. Galloway.
(b) Address Vandalia, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11/5/45 (Month) (Day) (Year)
(c) Place: burial or cremation VANDALIA-MO

18. (a) Signature of funeral director Clydie Willey
(b) Address Perry, Mo.

19. (a) 12-5-45 (Date received local registrar) (b) [illegible] E M Lucke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 3
year 1945 hour 8 minute 16 A M.

21. I hereby certify that I attended the deceased from 11-28, 1945 to 12-3, 1945
that I last saw her alive on 12-2-45, 19
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy

Due to ~~Arterio sclerosis~~

Due to Fracture of Hip

Other conditions Arterio sclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 (specify)
(b) Date of occurrence Mo 4
(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 [illegible] (M. D. or other)
Address Hannibal Mo Date signed 12-3-45

(Licensed Embalmer's Statement on Reverse Side)

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 Clyde Dilley

Licensed Embalmer No. 3820

P. O. Address Perry 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.

S. No. 2B
5M—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 364

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Levering Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 da. (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Katie Galloway
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec (Month) 6 (Day) 1868 (Year)
8. AGE: Years 78 Months 11 Days 27 If less than one day hr. min.
9. Birthplace (City, town, or county) Indiana (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

SUPPLEMENTARY

20. DATE OF DEATH: Month Dec Day 3 year 1945 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.
Immediate cause of death Fracture of hip — Duration 2 days
Due to
Due to Fall in home
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations 1860's
Of autopsy
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Accident
(b) Date of occurrence 11-27-45 Vandalia Mo
(c) Where did injury occur? (City, town, or county) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? yes (e) Means of injury
23. Signature [illegible] (M. D. or other)
Address Hannibal Mo Date signed 1-10-46

41818.