V. S. No. 2
00M—5-43
Rev. 5-17-39
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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. 1099

FILED JAN 27 1947

Registration District No. _____ Primary Registration District No. 1002. Registrar's No. 244

1. PLACE OF DEATH:

(a) County Jackson

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

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

(d) Length of stay: In hospital or institution 1 Day. (Specify whether years, months or days)

In this community unknown.

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson

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

(d) Street No. 318½ E 12th St
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME John H. Galbraith

3. (b) If veteran, name war NO

3. (c) Social Security No. 481-01-6454

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased Sept (Month) 6 (Day) 1884 (Year)

8. AGE: Years 62 Months 4 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Parkville Platte Co MO (City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business _____

MOTHER FATHER

12. Name Aubrey M. Galbraith

13. Birthplace Jamacia B.W.I. (City, town, or county) (State or foreign country)

14. Maiden name Margaret Ford

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

16. (a) Informant Wm Galbraith

(b) Address K C MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20 1947 (Month) (Day) (Year)

(c) Place: burial or cremation Memphis Mo

18. (a) Signature of funeral director Pandolfo Bros

(b) Address K. C. MO

19. (a) 1-18-47 (Date received by local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 15 year 1947 hour 10 minute 15 P. M.

21. I hereby certify that I attended the deceased from Chronic, 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	Duration
Pontine Hemorrhage	
~~Due to~~ Sub-Dural & Sub-arachnoid hemorrhage	
~~Due to~~ Skull fracture	

Other conditions (Include pregnancy within 3 months of death) 1952

Major findings: Of operations 40

Of autopsy yes - archive

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) Do not Know

(b) Date of occurrence 1-15-47

(c) Where did injury occur? Kc. Jackson MO (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public place (Specify type of place)

While at work? _____ (e) Means of injury Do not Know

23. Signature James Cecelia (M. D. or other)

Address 1424 Pr Ave Date signed 1-18-47

(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. Francis Walter

Licensed Embalmer No. 2744

P. O. Address. K C 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.