

FILED APR 14 1947

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. 3665

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether _____)
In this community 3 years
years, months or days

3. (a) PRINT FULL NAME William Thomas Galbraith

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, widowed

6. (b) Name of husband or wife Mary Bell 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 29, 1856
(Month) (Day) (Year)

8. AGE: Years 90 Months 9 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Imboden, Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Judge

11. Industry or business _____

12. Name Thomas Arbuthnot Galbraith
13. Birthplace Anderson County, Tenn
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Malinda Russell

15. Birthplace Anderson County, Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Clara Rothe
(b) Address 5351 Delmar Blvd.

17. (a) BURIAL (b) Date thereof 4-6-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MOUNTAIN VIEW, Mo.

18. (a) Signature of funeral director ROWLAND MORTUARY, INC.
(b) Address 4355 WASHINGTON AV.

19. (a) APR 7 1947 (b) J. F. Braddock
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5351 Delmar Blvd.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4
year 1947 hour 12:40 minute _____ P. _____ M.

21. I hereby certify that I attended the deceased from May 16, 1944
19 _____, to April 4, 1947
that I last saw him alive on April 4, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis Duration 1 day

Due to Fracture of Right hip 5 days

Due to _____

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

Major findings: Of operations _____
Of 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) Accident
(b) Date of occurrence March 31, 1947
(c) Where did injury occur? Masonic Home of Missouri
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? home

While at work _____ (Specify type of place) (e) Means of injury Falls

23. Signature [Signature] M. D. or other _____
Address 505 N. Grand Blvd. Date signed _____

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

MOTHER FATHER

9995

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..... *Lex Campbell*

Licensed Embalmer No..... *3881*

P.O. Address: *St Louis 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.