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 APR 22 1947

Registration District No. 12

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

Dr. Gentry
State File No. 13117
Registrar's No. 301

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1510 W. Lincoln (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 32 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39
(c) City or town Springfield 2 (If outside city or town limits, write "RURAL")
(d) Street No. 1510 W. Lincoln 6 (If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Joseph L. Galbraith
3. (b) If veteran, name war No
3. (c) Social Security No.
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Helen Squibb Galbraith
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 25 (Day) 1915 (Year)

8. AGE: Years	Months	Days	If less than one day
32	0	4	hr. min.

9. Birthplace Greene County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Guard
11. Industry or business U.S. Medical Center
FATHER
12. Name Gabe A. Galbraith 0
13. Birthplace Greene County (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name Mollie Galloway
15. Birthplace Greene County (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Emma Galbraith
(b) Address Springfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/47 (Month) (Day) (Year)
(c) Place: burial or cremation Maple Park
18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.
19. (a) 4-3-47 (Date received local registrar) (b) W E Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29 year 1947 hour 7 minute 15p.M.
21. I hereby certify that I attended the deceased from 3-29, 1947 to 3-29-, 1947 that I last saw him alive on 3-29-47, 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary occlusion	3 hours
Due to	
Due to	
Other conditions rheumatic fever (Include pregnancy within 3 months of death) chronic	20 yrs
Major findings: Of operations —	
Of autopsy —	

94P

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 0
23. Signature M.L. Gentry (M. D. or other)
Address Springfield Mo. Date signed 3-31-47

(Licensed Embalmer's Statement on Reverse Side)

APR 23 1947

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 Roy H. Mersey D.

Licensed Embalmer No. 4453

P. O. Address Springfield, 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.