

Registration District No. 149Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

## 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:  
3918 Charlotte  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution since 6-4-47  
(Specify whether  
In this community as above  
years, months or days)

3. (a) PRINT  
FULL NAMEDelbert D. Galle3. (b) If veteran,  
name war no.3. (c) Social Security  
No. no.4. Sex male 5. Color or  
race white6. (a) Single, widowed, married,  
divorced widowed6. (b) Name of husband or wife unknown6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased September 1, 1869  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>77</u>	<u>78</u>	<u>10</u>	<u>28</u>	hr. _____ min.

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Farmer11. Industry or business X12. Name Peter Galle 913. Birthplace unknown  
(City, town, or county) (State or foreign country)14. Maiden name unknown15. Birthplace unknown  
(City, town, or county) (State or foreign country)16. (a) Informant Family records(b) Address Excelsior Springs, Mo.17. (a) removal (b) Date thereof 7-29-47  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Excelsior Springs, Mo.18. (a) Signature of funeral director Stine & McClure(b) Address 3235 Gillham Plaza, K. C., Mo.19. (a) 8-1-47 (b) Gertrudine Holmes  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2026 Spruce  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country X

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29  
year 1947 hour 7:30 minute A. M.

21. I hereby certify that I attended the deceased from  
just before May 16, 1947 to July 29, 1947  
that I last saw him alive on July 27, 1947  
and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Malignant tumor of  
stomachDue to Carcinoma of  
Stomach

Due to \_\_\_\_\_

Other conditions 46 lb  
(Include pregnancy within 3 months of death)

Major findings: Stomach Carcinoma  
Of operations of Stomach  
Of autopsy \_\_\_\_\_

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 023. Signature C. J. Hunt, M.D. (M. D. or other) M.D.Address 1612 Prof. Bldg. K.C. Mo. Date signed 8/1/47

Dr. Hunt, Dr. Reyme, Dr. Cope

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 *J. Clair Sheppard*  
Licensed Embalmer No. *4179*  
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.