No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAY 18 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15447

Registration District No. 42 | Primary Registration District No. 1000 | Registrar's No. 534

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph 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: Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan
(c) City or town: St. Joseph, Mo. (If outside city or town limits, write "RURAL")
(d) Street No.: 36 E. Hyde Park Ave. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: MICHAEL DAVID GALLAGHER
3. (b) If veteran, name war: no
3. (c) Social Security No.: none

4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: single
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: March (Month) 6 (Day) 1948 (Year)

8. AGE: Years 0 | Months 0 | Days 1 | If less than one day: hr. min.

9. Birthplace: St. Joseph, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: Robert Gallagher
13. Birthplace: St. Joseph, Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Rose Marie Swope
15. Birthplace: St. Joseph, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant: Robert Gallagher
(b) Address: 36 E. Hyde Park Ave., City
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 7 1948 (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Park
18. (a) Signature of funeral director: Earl A. Clark
(b) Address: 120 Illinois Ave., St. Joseph, Mo.
19. (a) May 13, 1948 (Date received local registrar) (b) E. E. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 7 year: 1948 hour: 4 minute: 15 P.M.
21. I hereby certify that I attended the deceased from 5-6, 1948, to 5-7-, 1948 that I last saw him alive on 5-7, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Premature	6 mos
Due to:	
Due to:	
Other conditions: Premature age 6 mos (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy: 159

PHYSICIAN
Underline the cause of 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:
23. Signature: Albert K. Murrah (M. D. or other) M.D.
Address: St. Joseph, Mo. Date signed: 5-10-48

Jefferson City Printing Co.
(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. Earl A Clark

Licensed Embalmer No. 4238

P. O. Address St. Joseph 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.