

FILED APR 25 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15257  
Registrar's No. 857

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3069

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO</b> b. COUNTY _____	
b. CITY OR TOWN <b>RICHMOND HEIGHTS</b>	c. LENGTH OF STAY (In this place) _____	c. CITY OR TOWN <b>ST. LOUIS</b>	<b>2059</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. MARKS HOSPITAL</b>		d. STREET ADDRESS (If rural, give location) <b>6174 KINGSBURY</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>GOTFRIED</b> b. (Middle) <b>GALSTON</b> c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <b>APRIL-2-50</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>8-31-1879</b>
9. AGE (In years last birthday) <b>70</b>	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 1 YEAR Hours _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MUSICIAN</b>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <b>VIENNA-AUSTRIA</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>PHILLIP GALSTON</b>	13b. MOTHER'S MAIDEN NAME <b>CHARLOTTE BRAND</b>	14. NAME OF HUSBAND OR WIFE <b>HELEN GALSTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Helen Galston 6174 Kingsbury</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		<p align="center"><b>MEDICAL CERTIFICATION</b></p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Lymphatic Leukemia</b> ANTECEDENT CAUSES <b>10 yrs.</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <b>None</b> Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE. (Specify) <b>X</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>X</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>204.0</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from _____, 1950, to <b>4/3</b> , 1950, that I last saw the deceased alive on <b>4/3</b> , 1950, and that death occurred at <b>12:00 P.M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>[Signature]</b> (Degree or title) _____		23b. ADDRESS <b>634 N. Grand</b>	23c. DATE SIGNED <b>4/4/50</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	24b. DATE <b>APRIL-3-50</b>	24c. NAME OF CEMETERY OR CREMATORY <b>MISSOURI Crematory</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis MO</b>
DATE REC'D BY LOCAL REG. <b>4-3-50</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Donke</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>E. J. Schmitt 3125 Lafayette</b>	

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

*12/15/51*  
*W. H. Campbell & Ward*  
*Embalmer*

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 \_\_\_\_\_  
working under my personal supervision.

\_\_\_\_\_  
\_\_\_\_\_  
Signed.....  
Student Embalmer

Student Embalmer No.....  
Signed *No Embalming*  
Licensed Embalmer No. *SL C. 112*  
P. O. Address.....

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.