

FILED FEB 21 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5266

State File No.

BIRTH NO. _____ REG. DIST. NO. 184 PRIMARY REG. DIST. NO. 3038 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <u>LINN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>LINN</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>BROOKFIELD</u>	c. LENGTH OF STAY (in this place) <u>3 d</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>BROOKFIELD 0580</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BROOKFIELD HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>Rt # 3</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLIAM</u> b. (Middle) _____ c. (Last) <u>GALL</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 10, 1951</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JUNE 7, 1903</u>	9. AGE (In years last birthday) <u>47</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>3</u>	IF UNDER 11 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	11. BIRTHPLACE (State or foreign country) <u>NEW BOSTON, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>MIKE GALL</u>	13b. MOTHER'S MAIDEN NAME <u>KATHERINE OBERMAN</u>		14. NAME OF HUSBAND OR WIFE <u>OPAL M. GALL</u>		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Opal M. Gall Brookfield, Mo.</u>			
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>
	- ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>myocardiasis</u>				<u>6 yrs</u>
	DUE TO (c) <u>Respirator mellitus</u>				<u>17 yrs</u>
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>260X</u>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>None</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____		
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22. I hereby certify that I attended the deceased from 2-7, 1951, to 2-10, 1951, that I last saw the deceased alive on 2-10, 1951, and that death occurred at 12:15 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>L. C. Enoch, M.D.</u> (Degree or title)		23b. ADDRESS <u>Brookfield, Mo.</u>		23c. DATE SIGNED <u>2/12/51</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>FEB 12, 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Pleasant View Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>St. Catherine, Mo.</u>		
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DATE REC'D BY LOCAL REG. <u>2-12-1951</u>	REGISTRAR'S SIGNATURE <u>W B Enoch</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Garson Funeral Service, Ruskin, Mo.</u>		
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0580

Date Received: FEB 19 1951
DISTRICT HEALTH OFFICE #2
District File Number 2-57-41
Date Filed: FEB 19 1951

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed..... *C. A. Larson*.....

Licensed Embalmer No. *4037*

P. O. Address *Bucklin, 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.