

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **14388**

FILED APR 20 1955

BIRTH NO. _____		REG. DIST. NO. 325		PRIMARY REG. DIST. NO. 6096		Registrar's No. 15	
1. PLACE OF DEATH <i>Home</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY <i>Schuyler</i>		b. STATE <i>Mo</i>		b. COUNTY <i>Schuyler</i>			
b. CITY (If outside corporate limits, write RURAL and give township) <i>Rural Glenwood</i>		c. LEASED OR TOWN <i>Wagon</i>		c. CITY OR TOWN <i>Glenwood</i>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				e. STREET ADDRESS (If rural, give location) <i>Glenwood Township</i>			
3. NAME OF DECEASED (Type or Print)		a. (First) <i>IZETTA</i>		b. (Middle) <i>MAE</i>		c. (Last) <i>McGaldrick</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>w</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>APR 6 53</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		8. DATE OF BIRTH <i>MAY 1 1890</i>		9. AGE (In years last birthday) <i>64</i> If UNDER 1 YEAR Months <i>01</i> Days <i>5</i> If UNDER 1 HR. Hours <i></i> Min. <i></i>	
11. BIRTHPLACE (City and State or Foreign Country) <i>Davis County</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13a. FATHER'S NAME <i>Charles D Hoover</i>		13b. MOTHER'S MAIDEN NAME <i>HARRIET A DYSART</i>		14. NAME OF HUSBAND OR WIFE <i>LEON McGaldrick</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <i>Cles Roberts</i> ADDRESS <i>Glenwood</i>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cerebral thrombosis</i>		ANTECEDENT CAUSES				<i>Sharp</i>	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) <i>Hypertension</i>				<i>Year</i>	
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS				<i>Year</i>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <i>Coronary Heart Failure</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) <i>332X</i>			
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? _____			
22. I hereby certify that I attended the deceased from <i>July</i> , 1953, to <i>April 3</i> , 1955, that I last saw the deceased alive on <i>April 3</i> , 1955, and that death occurred at <i>11:30</i> a.m., from the causes and on the date stated above.							
23a. SIGNATURE <i>W. H. Stotter, M.D.</i>				23b. ADDRESS <i>Lancaster, Mo.</i>		23c. DATE SIGNED <i>April 8, 1955</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		24b. DATE <i>Apr 9 1955</i>		24c. NAME OF CEMETERY OR CREMATORY <i>IOOF</i>		24d. LOCATION (City, town, or county) (State) <i>Glenwood Mo</i>	
DATE REC'D BY LOCAL REG. <i>Apr 9 1955</i>		REGISTRAR'S SIGNATURE <i>Bessie R. J. Dwyer</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Morehead & Norman</i>		ADDRESS <i>Lancaster, Mo</i>	

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 4 1957

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
Signature of Student Embalmer

Signed *John E. Foster*
Licensed Embalmer No. *474*
P. O. Address *Fiskeville*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.