

FILED JUN 28 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19805

State File No. ....

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 3059 Registrar's No. 186

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bonne Terre, Mo.</u>		c. CITY OR TOWN <u>Esther</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>8 hrs</u>		STREET ADDRESS (If rural, give location) <u>705 4th Street</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bonne Terre Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Ella</u>	b. (Middle)	c. (Last) <u>Galvan</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>June 16 1955</u>

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 27, 1903</u>	9. AGE (In years last birthday) <u>51</u>	IF UNDER 1 YEAR: Months <u>5</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Francois Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
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13a. FATHER'S NAME <u>Guy Wendell Haile</u>	13b. MOTHER'S MAIDEN NAME <u>Ardetia Highley</u>	14. NAME OF HUSBAND OR WIFE <u>Arba Galvan</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>493-36-501</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Arba Galvan Esther, Missouri</u>	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c) <u>Hypertension</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>331X</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) (Min.)	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 2-4, 1947, to 6-16, 1955, that I last saw the deceased alive on 6-16, 1955, and that death occurred at 3:43 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>C. H. Appleberry MD</u>	23b. ADDRESS <u>Flu + River MO</u>	23c. DATE SIGNED <u>6-19-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6/19/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Francois Meo. Pk.</u>	24d. LOCATION (City, town, or county) (State) <u>Bonne Terre R. R. # 1 MO</u>
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DATE REC'D BY LOCAL REG. <u>June 19, 1955</u>	REGISTRAR'S SIGNATURE <u>Ethel Rudloff</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>C. Z. Boyer + Son</u>	ADDRESS <u>Desloge MO.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *B. T. Loyer*.....

Licensed Embalmer No. *364*

P. O. Address *Uxbridge*

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.