

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021361

STATE FILE NUMBER

FILED JUN 24 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2888

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY JACKSON	
b. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN INDEPENDENCE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hosp.		Length of stay in lb. 1WK.	d. STREET ADDRESS (If outside, give location) 7005 S. 1115 So. Dodgion Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First **Rufus** Middle **-** Last **GALBRAITH**

4. DATE OF DEATH Month **JUNE** Day **10** Year **1959**

5. SEX **MALE** 6. COLOR OF RACE **White** 7. MARRIED NEVER-MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH **APRIL 5, 1883** 9. AGE (In years last birthday) **76** IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **SALESMAN**

10b. KIND OF BUSINESS OR INDUSTRY **Shoe**

11. BIRTHPLACE (City and state or country) **ARNPRIOR, ONT. CANADA**

12. CITIZENSHIP OF WHAT COUNTRY? **CANADA**

13a. FATHER'S NAME **Joseph Galbraith** 13b. MOTHER'S MAIDEN NAME **-**

14. NAME OF HUSBAND OR WIFE **Nancy Victoria Galbraith**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **NONE**

17. INFORMANT **Leslie L. Galbraith** Address **K.C. Mo.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cerebral hemorrhage** INTERVAL BETWEEN ONSET AND DEATH **5 days**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **congestive heart failure** **2 weeks**

DUE TO (c) **arteriosclerosis** **5 years**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **331X**

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **2 June 59** to **10 June 59** and last saw ^{her} him alive on **10 June 59**

Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Jack M. Davis M.D.** 22b. ADDRESS **Raytown Mo** 22c. DATE SIGNED **11 June 59**

23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) **CREMATION** 23b. DATE **June 13, 1959** 23c. NAME OF CEMETERY OR CREMATORY **ELMWOOD** 23d. LOCATION (City, town, or county) (State) **KANSAS CITY, Mo.**

24. FUNERAL DIRECTOR ADDRESS **Kepley-Hinton Raytown, Mo** 25. DATE RECD. BY LOCAL REG. **6-14-59** 26. REGISTRAR'S SIGNATURE **new manshall**

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Jack M. Davis

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APR 3, 1930

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 R. Dillmo*

Licensed Embalmer No. *4531*

P. O. Address *Kansas City*

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.