

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014257

FILED VS MAY 2 1960

042

Primary Registration District No. 1000

Registrar's No. 479

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan									
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b most of life		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. MO. Meth. Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2425 Ashland Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First HATTIE Middle MAY Last GALLUP				4. DATE OF DEATH Month March Day 31 Year 1960									
5. SEX female		6. COLOR OR RACE white		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5/28/1872		9. AGE (last birthday) 87		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and state or country) Indiana		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME August M. Wylie				13b. MOTHER'S MAIDEN NAME Augusta C. Williams				14. NAME OF HUSBAND OR WIFE Edgar H. Gallup					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 491-28-2663		17. INFORMANT Address Mrs. Ralph Lovett, 2425 Ashland, St. Joseph,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction										INTERVAL BETWEEN ONSET AND DEATH minutes			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary arteriosclerosis												years	
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) generalized arteriosclerosis								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		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 p.m.													
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 6/27/57 to 3/31/60 and last saw her live on ? Death occurred at 6:10p. m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Donald J. Stallard M.D.						22b. ADDRESS 902 E. 2nd			22c. DATE SIGNED 4/20/60				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 4/2/1960		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery			23d. LOCATION (City, town, or county) (State) St. Joseph Mo.						
24. FUNERAL DIRECTOR ADDRESS Heaton-Bowman, St. Joseph, Mo.				25. DATE RECD. BY LOCAL REG. April 22, 1960		26. REGISTRAR'S SIGNATURE Mrs. Clark Bondell							

DOCUMENT

BY AFFIDAVIT OF D. J. Stallard, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 20 1960

STATEMENT BY LICENSED EMBALMER

MAY 8 1960

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William Speeding

Licensed Embalmer No. 453

P. O. Address St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.