URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED JUN 20 1960

-60-025321
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 590 Registrar's No. 1732

ENDED

1. PLACE OF DEATH a. COUNTY St. Louis	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Florissant — Length of stay in 1b: 2 mos.	c. CITY OR TOWN Florissant — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 500 Holiday Hill Dr. — Inside Limits: Yes ☒ No ☐	d. STREET ADDRESS (If outside, give location) 500 Holiday Hill Dr. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)	First: CHARLES	Middle: WILLIS	Last: GALLIAND	4. DATE OF DEATH	Month: June Day: 1 Year: 1960
5. SEX: Male	6. COLOR OR RACE: White	7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐	8. DATE OF BIRTH: 3-30-60 March	9. AGE (last birthday)	IF UNDER 1 YEAR: Months 2, Days 1 — IF UNDER 24 HR: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None	10b. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (City and state or country): Richmond Heights, Mo.	12. CITIZEN OF WHAT COUNTRY: USA		
13a. FATHER'S NAME: William Galliand	13b. MOTHER'S MAIDEN NAME: Wilda Farley	14. NAME OF HUSBAND OR WIFE: none			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Wm. Galliand — Address: 500 Holiday Hill Dr. Florissant, Mo.			

MEDICAL CERTIFICATION

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 Viral Pneumonia + Bronchitis — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c)

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

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 a.m. p.m. Month, Day, Year

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 _____, to _____ and last saw her/him alive on _____

Death occurred at 12:20A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John C. Murphy M.D. (Degree or title) — 22b. ADDRESS 801 S. Brentwood Clayton, Mo. — 22c. DATE SIGNED

John C. Murphy MD Asst. Health Commissioner

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal — 23b. DATE: 6-2-60 — 23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery — 23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR — ADDRESS: The Florissant Mortuary, Florissant, Mo. — 25. DATE RECD. BY LOCAL REG.: 6-2-60 — 26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by r

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Gene S Hutchins

Signature of Student Embalmer

Licensed Embalmer No. 4966

P. O. Address Florissant, Mo.

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