

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

51630-038361
4755

FILED VS. 1960 149

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

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mississippi</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jackson</u>		Length of stay in 1b <u>25 yrs</u>	c. CITY OR TOWN <u>Jackson</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4407 Roadland</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Willis</u> Middle <u>A.P.</u> Last <u>Galloway</u>			4. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>60</u>			
--	--	--	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/16/89</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
--------------------	-------------------------------	---	----------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Specemaker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Shop</u>	11. BIRTHPLACE (City and state or country) <u>St. Payne, Alabama</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
---	--	--	--

13. FATHER'S NAME <u>Alexander Galloway</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Annen</u>	14. NAME OF HUSBAND OR WIFE <u>Lorena Galloway</u>
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Lorena M. Galloway Home</u>
--	-------------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>perforated duodenal ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>with appendicitis & ulcer abscess</u>	
	DUE TO (c) <u> </u>	

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. <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 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 <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>
---	--

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>2-27-1960</u> to <u>10-13-1960</u> and last saw <u>him</u> alive on <u>10-13-1960</u> Death occurred at <u>10:55 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>H.L. Dwyer MD</u>	22b. ADDRESS <u>200 Cherry City</u>	22c. DATE SIGNED <u>10/13/60</u>
---	-------------------------------------	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>General</u>	23b. DATE <u>10-13-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>	23d. LOCATION (City, town, or county) <u>H.C. Mo.</u>
--	---------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <u>Melody McGilley-Eylan 20 W. Lincoln St. C. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-14-60</u>	26. REGISTRAR'S SIGNATURE <u>H.L. Dwyer</u>
--	--	---

DOCUMENT

MEDICAL CERTIFICATION

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert G. Landes

Licensed Embalmer No. 5103

P. O. Address K.C. Mo.

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.