

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-021820

STATE FILE NUMBER

Registration District No. 179 Primary Registration District No. 5667 Registrar's No. 75

AMENDED

FILED JUL 10 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Lincoln		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lincoln	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bedford Township		Length of stay in 1b 30 min.	c. CITY OR TOWN Old Monroe
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Lincoln County INSTITUTION Memorial Hospital		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Joan Marie Galloway			4. DATE OF DEATH Month Day Year July 4, 1961
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/9/50
9. AGE (last birthday) 10		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Louisiana, Mo.
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME Carlyle Galloway	
13b. MOTHER'S MAIDEN NAME Linda Gentry		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Carlyle Galloway Old Monroe, 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) Burned to death by overturned tractor.			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. <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 checked="" 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.) Subject was riding on a tractor which over-	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	turned & exploded. Gasoline caught fire burning subject fatally.		
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.) farm	20f. CITY, TOWN, OR LOCATION Hurricane Twp. Lincoln	COUNTY STATE Missouri.
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ 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) <i>Joseph J. Mark Sr.</i> CORONER		22b. ADDRESS Troy, Missouri	22c. DATE SIGNED 7/5/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE July 6, 1961	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR ADDRESS Ricks Funeral Home Elsberry, Mo.		25. DATE RECD. BY LOCAL REG. 7-5-1961	26. REGISTRAR'S SIGNATURE <i>Charlotte Leek</i>

JUL 14 1961

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

G. Galbreath

Licensed Embalmer No. 4012

P. O. Address Elkberg, Md

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.