

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045850

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 290 Primary Registration District No. \_\_\_\_\_ Registrar's No. 148 STATE FILE NUMBER \_\_\_\_\_

**FILED DEC 28 1961**

1. PLACE OF DEATH a. COUNTY <b>Pulaski</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>South Dakota</b> b. COUNTY <b>Minnehaha</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fort Leonard Wood</b>		Length of stay in 1b	c. CITY OR TOWN <b>Sioux Falls</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>US Army Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>231 Summit Avenue</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) <b>DONALD JAMES GALLAGHER</b>			4. DATE OF DEATH Month <b>December</b> Day <b>17</b> Year <b>1961</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10 Aug 1912</b>	9. AGE (last birthday) <b>49</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>	11. BIRTHPLACE (City and state or country) <b>Mason City, Iowa</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>John S. Gallagher</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Unknown</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 12 July 1938 to date</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>John S. Gallagher</b> Address <b>231 Summit Ave, Sioux Falls, So. Dak.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Heart Failure</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Shock</b>	
DUE TO (c) <b>Brain Laceration, Skull Fracture</b>		
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 checked="" type="checkbox"/> NO <input 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.) <b>Hit by Automobile - Intersections of South Dakota</b>
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20c. TIME OF INJURY Hour <b>7:50</b> p.m. Month, Day, Year <b>Dec 17, 61</b>	<b>and Alabama Streets at Fort Leonard Wood, Missouri</b>
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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.) <b>Highway</b>	20f. CITY, TOWN, OR LOCATION <b>Fort Leonard Wood</b>	COUNTY <b>Pulaski</b>	STATE <b>Missouri</b>
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21. I attended the deceased from **17 Dec 1961**, to **Dec 17, 1961** and last saw him alive on **Dec 17, 1961**  
Death occurred at **10:20 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>YUTAKA SAKURAI, Captain, MC</b>	22b. ADDRESS <b>US Army Hospital, Fort Leonard Wood, Missouri</b>	22c. DATE SIGNED <b>12-18-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12/19/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>	23d. LOCATION (City, town, or county) <b>Sioux Falls, S. D.</b>
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24. FUNERAL DIRECTOR <b>Carl J. Glenn</b>	ADDRESS <b>10th. st. Rolla, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-19-61</b>	26. REGISTRAR'S SIGNATURE <i>Esther Mae Anderson</i>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDED  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

JUN 29 1962

JUN 19 1962

**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 Carl J. Glenn

Licensed Embalmer No. 4707

P. O. Address Rolla, 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.