MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

45-62-030507
STATE FILE NUMBER

Registration District No. 99 Primary Registration District No. _____ Registrar's No. _____

FILED AUG 28 1962

DO NOT WRITE ON THIS STUB — AMENDED

VS 300
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS — DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — BY AFFIDAVIT OF — DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
a. COUNTY: Dekalb
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Maysville — Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Dekalb
c. CITY OR TOWN: Maysville — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Mary Middle: VioLA Last: GaLL
4. DATE OF DEATH: Month 8 Day 8 Year 62
5. SEX: F
6. COLOR OR RACE: W
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 4-20-1877
9. AGE (last birthday): 85 — IF UNDER 1 YEAR: Months: Days: — 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: Same
11. BIRTHPLACE (City and state or country): Tuney, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Robert Y. GaLLoway
13b. MOTHER'S MAIDEN NAME: Sarah Jane Potter
14. NAME OF HUSBAND OR WIFE: ALFred GaLL
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.: None
17. INFORMANT: VioLA Marie AusMan Address:

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) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage — 3 yrs ago
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 Oct 1956 to 8/8/62 and last saw her alive on 8/8/62
Death occurred at 3:00 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Harold Fowler (Degree or title) M.D.
22b. ADDRESS: Maysville Mo
22c. DATE SIGNED: 8/10/62
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Aug. 12 1962
23c. NAME OF CEMETERY OR CREMATORY: Lathrop Cem.
23d. LOCATION (City, town, or county) (State): Lathrop Mo.
24. FUNERAL DIRECTOR ADDRESS: Pilchek Funl Home, Maysville, Mo.
25. DATE RECD. BY LOCAL REG.: 8-25-62
26. REGISTRAR'S SIGNATURE: Gertie E. Dawdy

(Licensed Embalmer's Statement on Reverse Side)

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 Laurence J. Thompson

Licensed Embalmer No. 4735

P. O. Address Cameron, 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.