

NOV 12 1940
Registration District No. **999**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 Days
(Specify whether years, months or days)
In this community 25 Years

3. (a) PRINT FULL NAME Mrs. Henrietta Eliza Gilligan

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mr. Andrew J. Gilligan 6. (c) Age of husband or wife if alive 19 years

7. Birth date of deceased April 19 1867
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>5</u>	<u>19</u>	hr. min.

9. Birthplace Decatur Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business ---

12. Name John Atchison

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Anna Fruit

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant H. E. Gilligan

(b) Address 2914 Federal

17. (a) Burial (b) Date thereof Oct. 10, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 Brush-Creek Blvd.

19. (a) 10-10-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State New York (b) County Queens
(c) City or town Long Island City
(If outside city or town limits, write "RURAL")
(d) Street No. 4535 - 44th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? --- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 8th
year 1940 hour 9 minute 05 P. M.

21. I hereby certify that I attended the deceased from Sept 22, 1940 to Oct 8, 1940
that I last saw her alive on Oct 8, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death:
Cardiac failure
Atelectasis @ base of both lungs
Terminal broncho-pneumonia
Due to: 17 days
5 days
1 day

Due to: 126

Other conditions (Include pregnancy within 3 months of death)

Major findings: Cholelithiasis
Of operations: Cholecysto - Colic fistula
Of autopsy: Same + Cerebral edema & thrombosis cerebral vessel.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury !

23. Signature Kip Robinson (M. D. or other)

Address 928 Profers. Bldg. Date signed Oct 9, 40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *O. Hervey Quisenberry*
Licensed Embalmer No. *4070*
P. O. Address *A. 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 this body is not embalmed, fact should be so stated above.