

S. No. 2  
-11-10-39  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

41525

State File No. \_\_\_\_\_

Registrar's No. **4918**

Registration District No. **399**

Primary Registration District No. **1002**

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

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: **St. Luke's Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 Week**  
In this community **Non-resident** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Agnes Mullanigan**

3. (b) If veteran, name war.  3. (c) Social Security No. **no**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife  6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **May 5 1867**  
(Month) (Day) (Year)

8. AGE: Years **71** Months **7** Days **21** If less than one day hr. min.

9. Birthplace **Belleville Ill**  
(City, town, or county) (State or foreign country)

10. Usual occupation **own home**

11. Industry or business **Home**

12. Name **Thomas J. Mullanigan**

13. Birthplace **McCoubin Co Ill**  
(City, town, or county) (State or foreign country)

14. Maiden name **Mary A. Carroll**

15. Birthplace **Madison Co Ill**  
(City, town, or county) (State or foreign country)

16. (a) Informant **T. J. Mullanigan**

(b) Address **Lee's Summit Mo**

17. (a) **Burial** (b) Date thereof **12-28-46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Woodlawn Indep. Mo**

18. (a) Signature of funeral director **M. B. Langford**

(b) Address **Lee's Summit Mo**

19. (a) **12-26-40** (b) **M. M. Grove**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**  
(c) City or town **Lee's Summit Mo**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **207 East 4th**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **26**  
year **1946** hour **10** minute **45** AM.

21. I hereby certify that I attended the deceased from **12-1**, 19**46**, to **12-26**, 19**46**  
that I last saw **her** alive on **12-25**, 19**46**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Ca of both breasts with extension to lungs** 18 yrs  
Due to \_\_\_\_\_  
Due to **50**

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 **M. M. Grove** (M. D. or other) \_\_\_\_\_  
Address **Lee's Summit Mo** Date signed **12-26-40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.