

S. No. 2
OM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 18 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9409**
Registrar's No. **1111**

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Martin & Topping Sts.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution NO
In this community Unk. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson **48**

(c) City or town Unk.
(If outside city or town limits, write "RURAL") **0**

(d) Street No. Unk.
(If rural, give location) **0**

(e) Citizen of foreign country? No (Yes or No) **1**
If yes, name country

3. (a) PRINT FULL NAME Thomas Galligan

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

4. Sex Male 5. Color or race Wh 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 Unk.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

About 55 hr. min.

9. Birthplace Cincinnati Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation -- none

11. Industry or business --

MOTHER FATHER { 12. Name William Galligan

13. Birthplace Ireland **4**
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Hayes

15. Birthplace Ireland **4**
(City, town, or county) (State or foreign country)

16. (a) Informant Daniel Galligan

(b) Address 3638 Barberrry St., Cincinnati

17. (a) Burial (b) Date thereof 3/7/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cem.

18. (a) Signature of funeral director John P. Sheil

(b) Address R. C. Mo.

19. (a) 3-6-46 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 3 day 1
year 1946 hour 6:30 minute 0 M.

21. I hereby certify that I attended the deceased from 1946 to 1946;
that I last saw h. alive on 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Decapitation

Due to R.R. Trauma

Due to _____

Other conditions (include pregnancy within 3 months of death) 104 f

Major findings: Of operations _____

Of autopsy no
History & Inspection

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

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

(b) Date of occurrence 3-1-46

(c) Where did injury occur? R.C. Jackson Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
public place
(Specify type of place) (e) Means of injury R.R. Trauma

While at work? no

23. Signature James C. Kelly (M. D. or other) Chas. E. ...
Address 1424 Poplar St. Date signed 3-2-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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, fact should be so stated above.