

FILED OCT 6 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **80759**

BIRTH NO. _____		REG. DIST. NO. <u>156</u>		PRIMARY REG. DIST. NO. <u>2001</u>		Registrar's No. <u>423</u>	
1. PLACE OF DEATH a. COUNTY <b>Jasper</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jasper</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>Joplin</b>		c. LENGTH OF STAY (in this place) <b>13 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Cartersville</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION. <b>St Johns Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>306 North Pine</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>ARMINA</b>		b. (Middle) <b>BEAN</b>		c. (Last) <b>GALLIGAN</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 17, 1949</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>July 11, 1867</b>	
9. AGE (In years last birthday) <b>82</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>6</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House wife</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William E. Bean</b>		13b. MOTHER'S MAIDEN NAME <b>Christenia Sailor</b>		14. NAME OF HUSBAND OR WIFE <b>Peter Joseph Galligan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NO.</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mary Sailor Bailey Houston Tex.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary thrombosis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Extracapsular fracture of the neck of the left femur</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death. <b>Chronic myocarditis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>about 1/2 hr</b> <b>13 days</b> <b>571040</b> <b>21</b>	
19a. DATE OF OPERATION <b>9-12-49</b>		19b. MAJOR FINDINGS OF OPERATION <b>Open reduction of fractured neck of left femur</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Accident</b>		21b. PLACE OF INJURY (e.g., in or about home, in m. factory, street, office bldg., etc.) <b>Home</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Cartersville Jasper Mo.</b>		21f. HOW DID INJURY OCCUR? <b>Patient fell at her home</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>9 5 49</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					
22. I hereby certify that I attended the deceased from <b>9-5</b> , 1949, to <b>9-17</b> , 1949, that I last saw the deceased alive on <b>9-17</b> , 1949, and that death occurred at <b>10:15 Am.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>J. E. Hill</b>				23b. ADDRESS <b>410 Jackson, Joplin, Mo.</b>		23c. DATE SIGNED <b>9-24-49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>9/20/49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Webb City, Mo.</b>	
DATE REC'D BY LOCAL REG <b>9-27-49</b>		REGISTRAR'S SIGNATURE <b>Ed. W. James</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Hedge-Lewis Webb City, Mo.</b>			

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 10-3-49  
Jasper County Health Office

County File Number 49-9-762

Date Filed 10-3-49

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 .....  
Student Embalmer

Signed E. M. Hodge

Licensed Embalmer No. 2859

P. O. Address W. H. Hodge, W. Va.

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.