

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23755

State File No.

FILED AUG 2 - 1955

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6195**

1. PLACE OF DEATH a. COUNTY Illinois		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY Sangamon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri	c. LENGTH OF STAY (in this place) Stay	c. CITY OR TOWN Springfield	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> 8
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital		e. STREET ADDRESS (If rural, give location) 1431 E. Jackson Street.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Nell	b. (Middle) Josephine	c. (Last) Gaffigan	Month July	Day 16	Year 1955

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH April 29 1897	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator	10b. KIND OF BUSINESS OR INDUSTRY Central Illinois Public Service	11. BIRTHPLACE (City and State or Foreign Country) Springfield, Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Thomas J. Gaffigan	13b. MOTHER'S MAIDEN NAME Mary Fitzpatrick	14. NAME OF HUSBAND OR WIFE Nil
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Mary Giffigan, Springfield, Illinois	ADDRESS Springfield, Illinois
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Colon	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Coronary Occlusion			

19a. DATE OF OPERATION 4-14-55	19b. MAJOR FINDINGS OF OPERATION For advanced Carcinoma of Colon	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Springfield Sangamon 153 X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) None	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? None

22. I hereby certify that I attended the deceased from **4-2**, 19**55**, to **7-16**, 19**55**, that I last saw the deceased alive on **7-16**, 19**55**, and that death occurred at **4 A.** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. J. S. Allen M.D.	23b. ADDRESS 18 South Kings Highway St. Louis, Mo.	23c. DATE SIGNED 7-18-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7-16-55	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) Springfield, Illinois
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DATE REC'D BY LOCAL REG. JUL 18 1955	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John S. Dennis*.....

Licensed Embalmer No. *71*.....

P. O. Address *St. Lo*.....

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.