

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013297

STATE FILE NUMBER 1740

FILED APR 27 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1740

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>SENATE APT. HOTEL</b> <b>1015 EAST ARMOUR</b>		Length of stay in lb <b>73 YEARS</b>	d. STREET ADDRESS (If outside, give location) <b>SENATE APARTMENT HOTEL</b> <b>1015 EAST ARMOUR BLVD.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>LEE</b> Last <b>GALLAHER</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>3</b> Year <b>1959</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 12, 1885</b>	9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED-CIVIL SERVICE</b>	10b. KIND OF BUSINESS OR <b>BUREAU OF STATE GRAIN INSPECTION</b>	11. BIRTHPLACE (City and state or country) <b>JEFFERSON CITY, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>JAMES GALLAHER</b>	13b. MOTHER'S MAIDEN NAME <b>ALICE UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>MARY COLLINS GALLAHER</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>500-38-5802</b>	17. INFORMANT Address <b>1015 EAST ARMOUR</b> <b>MRS. MARY COLLINS GALLAHER KANSAS CITY, MO.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>middle</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Droplets melted</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <b>June 1957</b> to <b>April 3, 1959</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>March 25, 1959</b> Death occurred at <b>6:15 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Gerald Zander</b> (Degree or title) <b>MD.</b>	22b. ADDRESS <b>8640 Transit U.C. Mo</b>	22c. DATE SIGNED <b>4/4/59</b>
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23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>	23b. DATE <b>APRIL 6, 1959</b>	23c. NAME OF CEMETERY OR PLACE OF BURIAL <b>ELMWOOD CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
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24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b> ADDRESS <b>1331 BRUSH CREEK KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>4-6-59</b>	26. REGISTRAR'S SIGNATURE <b>Heve Marshall</b>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
Gerald Zander

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

Licensed Embalmer No. 3035

P. O. Address 2600 C. St.

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.