MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

6218

APR 24 1929

1. PLACE OF DEATH
County Harrison — Registration District No. 334 — File No. 485
Township Fox Creek — Primary Registration District No. 5-468 — Registered No.
City Bethany Mo (No. ..... St. ..... Ward)

2. FULL NAME John Quigley
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF X

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-13-1877

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
52	0	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Bethany
(STATE OR COUNTRY) Harrison Co. Mo.

PARENTS

10. NAME OF FATHER Franklin R Quigley
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Do not Know
12. MAIDEN NAME OF MOTHER Henrietta Springer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Indiana

14. INFORMANT Mrs Lottie Ray
(Address) Bethany Mo

15. FILED 4-10 W J Haines REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-14 1929

17. I HEREBY CERTIFY, That I attended deceased from 2-14, 1929, to 2-14, 1929, that I last saw him alive on 2-14, 1929, and that death occurred, on the date stated above, at 11 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral insufficiency
131 [illegible] (duration) 1 yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Nephritis
..... (duration) 4 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? NO DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) W L Warren, M. D
Feb 16, 1929 (Address) Gilman City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Springer Cemetery — DATE OF BURIAL 2-16 1929

20. UNDERTAKER S M Haas — ADDRESS Bethany Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.