

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.

2-67-74

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

Do not use this space
24722
3134

1. PLACE OF DEATH
 County Jackson Registration District No. 390
 Township New Primary Registration District No. 1002
 City Kansas City Mo (No. Little Sisters of Poor) St. _____ Ward _____

2. FULL NAME Ellen Quigly
 (a) Residence No. 53 1/2 Highland av St. 15 Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 35 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 25th 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
74 ~~1445~~ ~~18~~ ~~22~~

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

9. BIRTHPLACE (CITY OR TOWN) P. Pleasant Hill
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER Michael Quigly

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Murphy

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ireland
 (STATE OR COUNTRY)

14. INFORMANT Little Sisters of the Poor
 (Address) 53 1/2 Highland av

15. FILED 7/19/29 M. M. Crowe REGISTRAR
assh.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/18/29 1929

I HEREBY CERTIFY That I attended deceased from June 5th 1929 to 7-18-1929 that I last saw her alive on 7-17-1929, and that death occurred, on the date stated above, at 430 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Coronary Sclerosis
94 B
 (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY arteriosclerosis
 (SECONDARY) (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED 94 B
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH _____ DATE OF _____
 WAS THERE AN AUTOPSY _____
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) Dr. Johnson, M. D.
7/18, 1929 (Address) _____

*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 Mt Calvary H C Kas DATE OF BURIAL 7/29/29

20. UNDERTAKER W. F. Mayberry Mo ADDRESS City Mo.

15-1-2962

