

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

Do not use this space.

Cor 40583

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 2
 City K.C. Mo. (No. H.C. General Hospital) St. _____ Ward _____

File No. _____
 Registered No. 40583
 St. _____ Ward _____

2. FULL NAME

Margaret Riley Hagan
 (a) Residence No. 922 1/2 - 9th St. St. 2 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 Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 17 - 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
55 7 16

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Richard Riley

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

12. MAIDEN NAME OF MOTHER Catherine Tute

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

14. INFORMANT Thomas Riley
 (Address) 419 Myrandatta

15. FILED 12/5 29 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3 -

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12 - 7 19 29

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 11:00 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
diabetes mellitus

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 57 **(duration) _____ yrs. _____ mos. _____ ds.**

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy
 (Signed) Stacey M. Haly
1/4 . 19 29 (Address) Deputy coroner

*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 Calvary K.C. Mo. **DATE OF BURIAL** Dec 6 - 19 29

20. UNDERTAKER Mrs. C. L. Foster **ADDRESS** K.C. Mo.

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.

THIS IS A PERMANENT RECORD

