

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

Do not use this space.

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 36211
 Township Kaul Primary Registration District No. 1001 Registered No. 4617
 City Kansas City Mo (No. Little Sisters of Poor) St. _____ Ward _____

2. FULL NAME

Peter Quigley
 (a) Residence. No. 53 1/2 Highland av. St. 95 Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 1930 yrs. Norm. mos. 12 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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) Not Known

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
About 65 yrs.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Janitor
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER Peter Quigley

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

12. MAIDEN NAME OF MOTHER Mary Kearney

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 11/14 1930 M.M. Crowe
 REGISTRAR West

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-12 1930

17. I HEREBY CERTIFY, That I attended deceased from 5-1
 _____, 1930, to 11-12, 1930
 that I last saw h. in alive on 11-8, 1930, and that
 death occurred, on the date stated above, at 11-12a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis
131
97
 (duration) 5 yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) arteriosclerosis
 (duration) 10 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 1290

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

11/12 (Signed) Fred U. Drake, M.D.
 1930 (Address) 336 Lathrop

*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 M. St. Marip DATE OF BURIAL Nov 14 1930

20. UNDERTAKER Quirk & Tabin Co. ADDRESS 200 Lincoln

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.

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

