

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

Do not use this space.

38625

1. PLACE OF DEATH

County Buchanan Registration District No. 85
Township _____ Primary Registration District No. 1001
City St. Joseph (No. St. Joseph Hospital Ave. _____ St. _____ Ward)

File No. _____
Registered No. 1364

2. FULL NAME Neal Nicholas Gallagher

(a) Residence. No. 124 Massachusetts Ave., St. _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U.S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 2, 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
81 9 22

8. OCCUPATION OF DECEASED

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

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

PARENTS

10. NAME OF FATHER James Gallagher
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER Cecelia Gallagher
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Ireland

14. INFORMANT Miss Edith Gallagher
(Address) 164 Mass. Ave. - St. Joseph Mo.

15. FILED _____, 1930 John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) December 24 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 1930, to Dec 24, 1930, that I last saw h. ill alive on Dec 27, 1930, and that death occurred, on the date stated above, at 10-05 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis Prostate
obstructing

CONTRIBUTORY (SECONDARY) Arterio-sclerosis (duration) 7 yrs. mos. ds.
unknown (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF Dec 22-30

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) [Signature], M. D.

Dec. 24, 30 (Address) St. Joseph 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 Mt. Olivet Cemetery DATE OF BURIAL Dec. 26 19 30

20. UNDERTAKER A. D. Sidenfaden ADDRESS 1802 Union St.

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.

JAN 19 1931

DEC 26 1930

