

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.

REC'D AUG 22 1939

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

25824  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 398  
 (b) Township Blue Primary Registration District No. 5554  
 (c) City Raytown (d) Street No. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred 8 yrs. — mos. — ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)

Registered No. 247

2. PRINT FULL NAME 436 CATHERINE MARY HALLAGHER

(a) Residence, No. Raytown - L. K. C. #3 St.  Missouri  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 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 Peter Gallagher

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 9, 1863

7. AGE YEARS 79 MONTHS 3 DAYS 18 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housekeeper  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

FATHER 13. NAME Michael Weston

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) France

MOTHER 15. MAIDEN NAME Mary McElroy

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

17. INFORMANT (ADDRESS) John & Frank Gallagher  
L. K. C. - Raytown

18. BURIAL, CREMATION, OR REMOVAL PLACE Cyfel, Kansas DATE July 31, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ed Clark Pigart  
Raytown, Mo.

20. FILED July 30, 1939 W. L. Cook  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-27-1939

22. I HEREBY CERTIFY, That I attended deceased from 7-27-1939 to 7-27-1939  
 I last saw him alive on 7-27-1939 Death is said to have occurred on the date stated above, at 445 P.M.  
 The principal cause of death and related causes of importance were as follows:

Myocardial degeneration with valvular deficiency (Date of onset 6-15-39)  
Other contributory causes of importance:  
Senility with Insanitation

Name of operation Clueval Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? no Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) J. H. Hoffman, M. D.  
 (Address) Raytown Mo  
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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

*E. Clark Regent*

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

*E. Clark Regent*

Licensed Embalmer No. *3983*

P. O. Address. *Raytown Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**