

No. 2
-1-4-41
5-17-39
1 X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30669

PRINTED OCT 13 1941

Registrar's No. 3426

Registration District No. 249

Primary Registration District No. 1002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Marys Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 46 years (years, months or days)

3. (a) PRINT FULL NAME James M. Gillen

3. (b) If veteran, name war No

3. (c) Social Security No. 486-26-2354

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced / Married

6. (b) Name of husband or wife Mary E. Gillen

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased February 12 1884
(Month) (Day) (Year)

8. AGE: Years 57 Months 7 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Newark, New Jersey
(City, town, or county) (State or foreign country)

10. Usual occupation Parking Station Operator

11. Industry or business _____

MOTHER FATHER { 12. Name Michael Gillen

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Rose Gallagher

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary E. Gillen

(b) Address 1212 West 41

17. (a) Burial (b) Date thereof 9/15/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Quirk & Tabin Co.

(b) Address St. C. M. Crowe

19. (a) 9/14/41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1212 West 41st St.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 13
year 1941 hour 5 minute 25 A. M.

21. I hereby certify that I attended the deceased from 9 9 1941 to 9 13 1941;
that I last saw him alive on 9 9 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to 9 9 41

Due to Chronic Hypertension

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. J. Barneke (M. D. or other) _____

Address 1212 West 41st Date signed 9/14/41

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

Signed.....

Harold Perry

Licensed Embalmer No.....

4097

P. O. Address.....

K.C. 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, fact should be so stated above.