

FILED FEB 24 1944

State File No. _____

229

Registration District No. 147

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: K. C. General Hospital No. 1
(d) Length of stay: In hospital or institution 17 days
In this community 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 3420 E. 9 St.
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Nellie Mulligan
(b) If veteran, name war _____ (c) Social Security No. no

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife Wm Mulligan 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb. 20 1861

8. AGE: Years 82 Months 10 Days 14 If less than one day _____

9. Birthplace Indiana

10. Usual occupation at home

11. Industry or business _____

12. Name unk Shoemaker
13. Birthplace no record
14. Maiden name no record
15. Birthplace no record

16. (a) Informant Orville Drough

(b) Address 2904 Michigan

17. (a) Burial (b) Date thereof Jan 17-44

(c) Place: burial or cremation Green Haven

18. (a) Signature of funeral director Mr. E. K. Fortae
(b) Address 918 Brooklyn
19. (a) Jan 15 1944 (b) J. B. Brown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 14
year 1944 hour 5 minute A. M.

21. I hereby certify that I attended the deceased from December 28 1943 to January 14 1944
that I last saw her alive on January 14 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease

Due to _____
Due to _____

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

Major findings:
Of operations _____
Of autopsy _____

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

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

23. Signature A. E. Upsher (M. D. or other) _____
Address Med. Dir. Gen'l Hosp. Date signed 1-14-44

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

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 M. S. Redmon

Licensed Embalmer No. 2737

P.O. Address

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.