

FILED OCT 13 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30371**
4074

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson 5		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson 3758	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 30 years		d. STREET ADDRESS (If rural, give location) 5331 Highland	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Little Sisters of the Poor			

3. NAME OF DECEASED (Type or Print) a. (First) PETER b. (Middle) MULLIGAN c. (Last) MULLIGAN			4. DATE OF DEATH (Month) (Day) (Year) Sept 17 1951		
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 0	8. DATE OF BIRTH July 12 1869	9. AGE (In years last birthday) 82	10 UNDER 1 YEAR Months	10 UNDER 1 YEAR Days	10 UNDER 1 YEAR Hours	10 UNDER 1 YEAR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired--Gas Service			10b. KIND OF BUSINESS OR INDUSTRY K. C. Mo		11. BIRTHPLACE (State or foreign country) Lexington, Missouri 0		12. CITIZEN OF WHAT COUNTRY? U. S. A.	

13a. FATHER'S NAME JOHN MULLIGAN	13b. MOTHER'S MAIDEN NAME MARY PHILLIPS	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 90-16-2295-A	17. INFORMANT'S SIGNATURE OR NAME Mrs Thomas Claffare ADDRESS 4436 Genessee
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 12 hrs
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last Arterio Sclerosis		33 1/2
DUE TO (c) _____		20 yr
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from **3/19**, 19**51**, to **9/17**, 19**51**, that I last saw the deceased alive on **9/17**, 19**51**, and that death occurred at **6:00 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE Joseph A. Fogarty (Describe or title) Dr.	23b. ADDRESS 402 Northman Bldg. 63 Mo	23c. DATE SIGNED 9/20/51
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24. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept 19 1951	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
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DATE REC'D BY LOCAL REG. 9-24-51	REGISTRAR'S SIGNATURE Staldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Dwight P. Owen ADDRESS 20 West Linwood
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Forrest D. Goldsboro*.....

Licensed Embalmer No. *4714*.....

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.