

FILED OCT 4 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30589

State File No.

4267

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

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
c. LENGTH OF STAY (In this place) <u>40 YEARS</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>RESEARCH HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>94 1028 WEST 58TH STREET</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>ESTHER</u>	b. (Middle) <u>IRENE</u>	c. (Last) <u>GALLAGHER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT 3, 1954</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>OCT 8, 1913</u>	9. AGE (In years last birthday) <u>40</u>	If UNDER 1 YEAR Months Days Hours Min.	If UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INTERIOR DECORATOR</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FURNITURE CONSULTANT</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>KANSAS CITY, KANSAS</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>ANDREW J. RAINES</u>	13b. MOTHER'S MAIDEN NAME <u>DOROTHY DICKEY</u>	14. NAME OF HUSBAND OR WIFE <u>C. R. GALLAGHER</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>C. R. GALLAGHER</u>	ADDRESS <u>1028 W. 58TH ST. KANSAS CITY, MO.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of the breast</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>1704</u>

19a. DATE OF OPERATION <u>11-22-49</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of right breast</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 11/21, 1954, to 9/3, 1954, that I last saw the deceased alive on 9/3, 1954, and that death occurred at 2:35A. m., from the causes and on the date stated above.

23a. SIGNATURE <u>E.A. QUERT</u>	(Degree or title) <u>M.D. M.Sc.</u>	23b. ADDRESS <u>1612 Prof. Bldg. Kansas City 6, Mo</u>	23c. DATE SIGNED <u>9/3/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>SEPT. 7, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
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DATE REC'D BY LOCAL REG. <u>9-7-54</u>	REGISTRAR'S SIGNATURE <u>Newman Minshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>D.W. NEWCOMER'S SON'S</u>	ADDRESS <u>K.C.Mo.</u>
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- 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.....
Signature of Student Embalmer

Signed *James T. Dewar*.....

Licensed Embalmer No. *44*.....

P. O. Address *7th Ave*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.