FILED NOV 10 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33238

State File No.

BIRTH NO. 506 2001-55 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4650

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KANSAS CITY
c. LENGTH OF STAY (in this place): Life / HOURS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. LUKE'S HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: KANSAS CITY, MO. b. COUNTY: JACKSON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KANSAS CITY, Rural
d. STREET ADDRESS (If rural, give location): 30 E. 97 } PARENTS

3. NAME OF DECEASED (Type or Print): a. (First) INFANT BOY b. (Middle) c. (Last) GALLAGHER

4. DATE OF DEATH (Month) 1 (Day) 13 (Year) 1955

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): N.M.
8. DATE OF BIRTH: 1-10-55
9. AGE (In years last birthday): — If under 1 year: Months — Days 2 If under 24 hrs.: Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and State or Foreign Country): KANSAS CITY, MO
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: ANDREW E. GALLAGHER
13b. MOTHER'S MAIDEN NAME: MARTHA J. BRISCOE
14. NAME OF HUSBAND OR WIFE: NONE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: HOSPITAL RECORDS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) IMPERFORATE ANUS — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) — 7561

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* DEHYDRATION; CONGENITAL HEART DISEASE; MONGOLISM. — 2 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-10, 1955, *to* 1-13, 1955, *that I last saw the deceased alive on* 1-13, 1955, *and that death occurred at* 11 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Paul A. Hogue, M.D.
23b. ADDRESS: 315 Nichols Rd.
23c. DATE SIGNED: 10-29-55

24a. BURIAL, CREMATION, REMOVAL (Specify): HOSPITAL DISPOSAL
24b. DATE: 1/24/56
24c. NAME OF CEMETERY OR CREMATORY: —
24d. LOCATION (City, town, or county) (State): ST. LUKES HOSPITAL MO.

DATE REC'D BY LOCAL REG.: 10-29-55
REGISTRAR'S SIGNATURE: Neva Marshall
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: St. Luke's Hosp. K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 ..... Signed.....

Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, front should be so stated above.