

Health,
Welfare,
Public
Service

FILED NOV 1 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35813

STATE FILE NUMBER 4700

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300
1-57

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 137 N. Hardesty		Length of stay in 1b 23 yrs.	d. STREET ADDRESS (If outside, give location) 137 N. Hardesty		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Margaret Middle Mary Last Gallagher			4. DATE OF DEATH Month 10 Day 11 Year 57		
5. SEX Fe	6. COLOR OR RACE Wh.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-4-1895	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Leavenworth Co., Kansas		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Michael Callahan		13b. MOTHER'S MAIDEN NAME Mary Ellen O'Connor		14. NAME OF HUSBAND OR WIFE Marvin Gallagher	
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. —		17. INFORMANT Address Marvin Gallagher 137 N. Hardesty KCMO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Acidosis (Diabetes Mellitus)				INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Acute vomiting & diarrhea (Gastroenteritis)				48 hrs.	
DUE TO (c) _____				260 X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 8/30/55 to 10/11/57 and last saw her alive on July 23, 57 . Death occurred at 2 AM on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Claude C. Farley M.D. (Degree or title) 0			22b. ADDRESS 4526 Posco, KCMO.		22c. DATE SIGNED 10/11/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-12-57	23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR Melody-McGilley-Eylar		ADDRESS KCMO.		25. DATE RECD. BY LOCAL REG. 10-11-57	26. REGISTRAR'S SIGNATURE Irene Marshall

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Claude C. Farley

All diseases in Part I must be causally related.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

Dr. Farley
4526 Passo
VA. 6344



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 *J. W. Wair*

Licensed Embalmer No. *4650*
P. O. Address *K @ Ma*

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.