

**DI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH** **59-025542**  
**FILED VS JUL 21 1959** STATE FILE NUMBER

Registration District No. 746 Primary Registration District No. 3026 Registrar's No. 322

8/4/59 XFL  
 Blank DOCUMENT  
 MEDICAL CERTIFICATION  
 Mount Olivet Cemetery  
 BY AFFIDAVIT OF Informant  
 23c.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>JACKSON</u>  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Illinois</u> b. COUNTY <u>Cook</u>                     |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u>  |   | c. CITY OR TOWN <u>CHICAGO</u>  |   |
| Length of stay in 1b <u>1 Month</u>  |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3502 S. Bowen</u>   |   | d. STREET ADDRESS (If outside, give location) <u>1621 E. 70th</u>   |   |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>MILTON VAN CLEAVE GAFFNEY</u>  |   |   | 4. DATE OF DEATH Month Day Year<br><u>July 17 1959</u>  |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAR 29 1890</u>   |
| 9. AGE (last birthday) <u>69</u>   |   | IF UNDER 1 YEAR Months Days   | IF UNDER 24 HR Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sales Manager</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Packing Co.</u>   | 11. BIRTHPLACE (City and state or country) <u>Springfield, Illinois</u>   |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>  |   | 13a. FATHER'S NAME <u>Emory GAFFNEY</u>   |   |
| 13b. MOTHER'S MAIDEN NAME <u>Antoinette Burgess</u>  |   | 14. NAME OF HUSBAND OR WIFE <u>Elizabeth GAFFNEY</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W.I.</u>   |   | 16. SOCIAL SECURITY NO. <u>322-03-5563A</u>   |   |
| 17. INFORMANT <u>Kathryn Brown</u>   |   | Address <u>Independence, Mo.</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO (b) <u>Chronic Emphysema</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u><br><u>10 years</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |   |   | PART III. If deceased was female, was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>6/8/59</u> to <u>7/17/59</u> and last saw her/him alive on <u>7/17/59</u><br>Death occurred at <u>11:15 AM.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.   |   |   |   |
| 22a. SIGNATURE (Degree or title) <u>[Signature]</u>  |   | 22b. ADDRESS <u>10901 W. 110th St. Mo</u>   | 22c. DATE SIGNED <u>7/17/59</u>   |
| 23a. BURIAL, CREATION, REMOVAL (Specify) <u>Removal</u>  | 23b. DATE <u>7/17/59</u>  | 23c. NAME OF CEMETERY OR CRYPTORY <u>Mount Olivet Cemetery</u>  | 23d. LOCATION (City, town, or county) (State) <u>Aurora, Illinois</u>   |
| 24. FUNERAL DIRECTOR ADDRESS <u>Sidman Mortuary Service, K.C. Mo</u>   |   | 25. DATE RECD. BY LOCAL REG. <u>7-17-59</u>   | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |

JUL 2 1959

VS JUL 29 1959

VS AUG 4 1959

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed John R. Dieder

Licensed Embalmer No. \_\_\_\_\_

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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