

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

17064

1. PLACE OF DEATH

County Jackson
Township St. Louis
City Kansas City (No. Kansas City Gen Hosp)

Registration District No.
Primary Registration District No.

File No.
Registered No. 2033
St. 9 Ward

2. FULL NAME

(a) Residence. No. 1304 Ord St. 9 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-2-1863

7. AGE: YEARS 64 MONTHS 9 DAYS 4 IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Gen Fender
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wisconsin

10. NAME OF FATHER Michael Daly

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland

12. MAIDEN NAME OF MOTHER Margaret Murphy

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland

14. INFORMANT Reverend Albert (Address) Kansas City Gen Hosp

15. FILED 5-7 1928 M M Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-6-1928

17. I HEREBY CERTIFY That I attended deceased from 5-3-1928 to 5-6-1928 that I last saw him alive on 5-6-1928, and that death occurred, on the date stated above, at 4:00 P.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
Pericarditis Aneurysm
157A
71A

CONTRIBUTORY (SECONDARY) 1000W

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) P. Williams M. D.

5-6, 1928 (Address) Gen Hosp

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE of INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

St. Joseph's 7 1928
20. UNDERTAKER St. Joseph's ADDRESS 410 East 15

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

