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

Do not use this space.
30754

1. PLACE OF DEATH
County: Jackson — Registration District No.: 399
Township: Raw — Primary Registration District No.: 1002
City: Kansas City (No. Kansas City Genl Hosp St. Ward)
File No.: 4049
Registered No.:

2. FULL NAME Gaffey, John
(a) Residence. No. 401½ Main St., / Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 17 1867

7. AGE: Years 61 | Months 3 | Days 12 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Dent Know.
(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) Dent Know

PARENTS
10. NAME OF FATHER Dent Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Ireland

14. INFORMANT Record Clerk
(Address) K. C. Genl Hosp.

15. FILED 10/5, 1928 M. M. Crane
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-29 1928

17. I HEREBY CERTIFY, That I attended deceased from 8-10, 1928, to 9-29, 1928, that I last saw h. alive on 9-29, 1928, and that death occurred, on the date stated above, at 7:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Malignant papilloma of Bladder
518 49
1350 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Hematuria
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) P. E. Williams, M. D
10-1, 1928 (Address) Supt K. C. Genl 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: Fields. — DATE OF BURIAL: 10-5 1928

20. UNDERTAKER: O. H. Mast — ADDRESS: K. C. Mo

WRITE PLAINLY, 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.