

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

Do not use this space.

1920

**1. PLACE OF DEATH**

County Jackson  
Township New  
City Kansas City (No. 6016 Swope Parkway)

Registration District No. 399

Primary Registration District No. 1002

File No. 515

Registered No. 515

St.

Ward

**2. FULL NAME**

Ellen West O'Brien

(a) Residence. No. 6016 Swope Parkway St., 16 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

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.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

F.

**4. COLOR OR RACE**

white

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

widow

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

J.P. O'Brien

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

June 10, 1848

**7. AGE**

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

80

7

21

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

Housewife

(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)

St. Louis

Mo

**10. NAME OF FATHER**

Geo H West

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Baltimore

md

**12. MAIDEN NAME OF MOTHER**

Ellen Boyle

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Philly

Pa

**14.**

INFORMANT (Address)

Mrs O Hoffman  
6016 Swope Parkway

**15.**

FILED

19

2-1-29 M. M. Girdle REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

Jan. 31, 1929

**17.**

I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1929, to Jan. 31, 1929, that I last saw h. on alive on Jan. 31, 1929, and that death occurred, on the date stated above, at 5 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

748 Thrombosis coronary artery  
29

**CONTRIBUTORY (SECONDARY)**

arterio sclerosis

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH?

**19. DID AN OPERATION PRECEDE DEATH? (DATE OF)**

WAS THERE AN AUTOPSY? No

**WHAT TEST CONFIRMED DIAGNOSIS?**

Symptoms

(Signed)

Orchar Hoffman

M. D

1/31-1929 (Address) 1235 Wialto bldg

\*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 Louis, Mo

2/1/29

**20. UNDERTAKER**

**ADDRESS**

H. J. Mayberry City, Mo

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.

2350

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2

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