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

Do not use this space.
10572

1. PLACE OF DEATH

County: Jackson — Registration District No. 399
Township: Kaw — Primary Registration District No. 1002
City: Kansas City (No. St. Mary's Hospital St. Ward)

File No.
Registered No. 11475

2. FULL NAME Miss Anna May Gaffney

(a) Residence. No. 206 West 34th St., 5 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 11 1898

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
30	9	21	

8. OCCUPATION OF DEACESED
(a) Trade, profession, or particular kind of work: Larabee Flour Mills
(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) Illinois

PARENTS
10. NAME OF FATHER Timothy Gaffney
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Illinois
12. MAIDEN NAME OF MOTHER Annie Gallagher
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Illinois

14. INFORMANT Mrs Annie Gaffney
(Address) 206 West 34th

15. FILED 3/4 1929 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 2 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1927 to Mch 2 1929 that I last saw him alive on Mar 1 1929 and that death occurred, on the date stated above, at 9:45 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicaemia, Pneumonia
#30
30 m
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (SECONDARY) Acty mitral
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? yes DATE OF
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) H J McKenna, M. D
3/3 1929 (Address) 100 Medical Arts 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: St. Mary's Cemetery
DATE OF BURIAL 3/5 1929

20. UNDERTAKER: Quirk & Tobin Co-- 20 W
ADDRESS: Linwood

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.

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