

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

Do not use this space.

24886

3300

**1. PLACE OF DEATH**

County Jackson  
Township TCAN  
City Kansas City (No. Kansas City)

Registration District No. 399  
Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

O'Day, Gertrude  
(a) Residence No. 1221 Harrison St. Ward 2  
(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 Female 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 \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-1-1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
68 7 30

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work none  
(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) Missouri

10. NAME OF FATHER James Warren

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

12. MAIDEN NAME OF MOTHER Mahelra Hobbs

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

14. INFORMANT Records clerk (Address) Kansas City

15. FILED 8/1/29 Wm. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-31-1929

17. I HEREBY CERTIFY, That I attended deceased from 7-8-1929 to 7-31-1929 that I last saw him alive on 7-31-1929, and that death occurred, on the date stated above, at 8:15 P.M.

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

Senility  
chronic arthritis  
09B

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.  
8-1-1929 (Address) Sup't. K. B. Emstorf

\*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 Leavenworth DATE OF BURIAL Aug 7 1929

20. UNDERTAKER Kelley ADDRESS Kelley

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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