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

Do not use this space.

14902

791

1. PLACE OF DEATH

County ..... Registration District No. 1003 ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 4320

City Mo. (No. City Hospital St. ..... Ward)

20349

2. FULL NAME Kate (Gaynor) Gaynor

(a) Residence. No. City Infirmary St. 13 Ward ..... (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 37 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	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) About 1864

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
About 65	Unknown		

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Wm Harakes

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

12. MAIDEN NAME OF MOTHER May Dohle

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

14. INFORMANT E. Rowan
(Address) City Hospital

15. FILED ..... 19.. Max L. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 29 1930

17. I HEREBY CERTIFY, That I attended deceased from March 24, 1930, to April 29, 1930 that I last saw h. alive on April 29, 1930, and that death occurred, on the date stated above, at 6:17 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

93C

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 90B

..... (duration) ..... yrs. ..... mos. ..... ds.

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) John Hotz, M. D.

4/30, 1930 (Address) City Hospital

*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
Calvary	5/1 1930

20. UNDERTAKER	ADDRESS
W. A. Stock Undt Co	2176 E Grand

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.

Layner.