

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

Do not use this space.

26743

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_  
Township Kaw Primary Registration District No. 399  
City Kansas City (No. St. Marys' Hospital 002)

File No. \_\_\_\_\_  
Registered No. 3348 St. \_\_\_\_\_ (Ward)

**2. FULL NAME** John Gahan Fahey

(a) Residence. No. 3908 Wyoming St. 7 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 20 1899

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>30</u>	<u>9</u>	<u>10</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Clerk  
(b) General nature of industry, business, or establishment in which employed (or employer). Mercer Hotel  
(c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Missouri

**PARENTS**

10. NAME OF FATHER John P Fahey

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

12. MAIDEN NAME OF MOTHER Katherine Gahan

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

**14.**

INFORMANT John P Fahey  
(Address) 3908 Wyoming

**15.**

FILED 9/12 1930 M. M. Crowe  
REGISTRAR

**2) MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 10 1930 1930

17. I HEREBY CERTIFY, That I attended deceased from 8 10, 1930, to 8 11, 1930, that I last saw him alive on 8 11, 1930, and that death occurred, on the date stated above, at 8:25 A m.

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

Acute Encephalitis  
NOTE PILENIP (Encephalitis)

CONTRIBUTORY (SECONDARY) Dysphilia  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy, Virology

(Signed) L. J. Fahey M. D.

8. 12. 1930 (Address) 410 Argyle

\*State the DISEASE CAUSING DEATH, or in death 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 Cemetery

8/13/30<sup>19</sup>

**20. UNDERTAKER**

ADDRESS

Quirk & Tobin--20 W 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.

