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

Do not use this space.

31510

File No. 4008

Registered No.

1. PLACE OF DEATH

County Jackson — Registration District No. 3

Township Kaw — Primary Registration District No.

City Kansas City (No. 7140 Oak St. Ward)

2. FULL NAME Patrick Gainey

(a) Residence, No. 7140 Oak St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 23 1878

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	53		6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Butcher

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Cudahy

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

FATHER

13. NAME Patrick Gainey

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

MOTHER

15. MAIDEN NAME Catherine Newman

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

17. INFORMANT (ADDRESS) Mrs Margaret Gainey 7140 Oak

18. BURIAL, CREMATION, OR REMOVAL
PLACE St. Marys' Cemetery DATE 10/ 31 19

19. UNDERTAKER (ADDRESS) Quirk & Tobin Co. 20 W Linwood

20. FILED 9 - 30 - 1931 M. M. Crowe Asst Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 29 1931 19

22. I HEREBY CERTIFY, That I attended deceased from 6-21, 1931, to 9-29, 1931

I last saw him alive on 9-28, 1931. Death is said to have occurred on the date stated above, at 8:05 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Lung Abscess - (not Tubercular) 102 pp 87 114 B	Pneumonia 4-10-31
Other contributory causes of importance:	
Cerebral Embolus	12 days
Right Hemoplegia	

Name of operation none Date of

What test confirmed diagnosis? Clinical, X Ray, Autopsy Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Fred E. Angle, M. D.

(Address) #14-16 Harris Bldg.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

31570.

1. PLACE OF DEATH

County ..... Registration District No. 399 File No. .....

Township ..... Primary Registration District No. 1002. Registered No. 4008

City Kansas City (No. ....., ... St. ..... Ward)

2. FULL NAME Patrick Gainey

(a) Residence. No. 7140 Oak St., 8 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 M | 4. COLOR OR RACE W. | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 23, 1878

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(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)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 1/28, 1931 M. M. Cerowe Assn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1931

17. I HEREBY CERTIFY, That I attended deceased from June 21, 1931 to Sept 29, 1931 that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lung Excess - not tubercular
Pneumonia, Lobar
(duration) Apr. 10, 1931

CONTRIBUTORY (SECONDARY) Cerebral Embolus
Right Hemiplegia (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 108
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? Clinical, X Ray
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*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 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY

S-31510

122
4.86

122
3
1.66