

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.

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

15989

PLACE OF DEATH
County Jackson Co
Township Bloss or Village Independence Mo or City Independence Mo (NO. 18)
Registration District No. 398 Primary Registration District No. 3019 Registered No. 101
St. 4 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME John J. Downey

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)	DATE OF DEATH <u>May 3, 1914</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>June 14, 1862</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,	
AGE <u>57 yrs. 10 mos. 19 ds.</u>			that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Section Foreman</u>			The CAUSE OF DEATH* was as follows: <u>Valvular Insufficiency</u>	
(b) General nature of industry, business, or establishment in which employed (or employer)			<u>92A</u> <u>92B</u> (Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Franklin Mo</u>			Contributory <u>Endocarditis</u> (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER <u>John Downey</u>		(Signed) <u>Fritz Wouninghoff</u> M. D.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ireland</u>		<u>5/31/14</u> (Address) <u>U.S. Ry Bldg</u>	
	MAIDEN NAME OF MOTHER <u>May Coblin</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ireland</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				
(Informant) <u>Mrs J. W. H. Harris</u>			Where was disease contracted If not at place of death? Former or usual residence _____	
(ADDRESS) <u>Maywood Mo</u>			PLACE OF BURIAL OR REMOVAL <u>Catholic Cemetery</u>	
Filed <u>May 4, 1914</u> <u>F. L. Look</u> REGISTRAR			DATE OF BURIAL <u>3/5</u> , 191 <u>4</u>	
			ADDRESS <u>Independence Mo</u>	

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH
 County Jackson
 Township _____
 Village _____
 or _____
 City Independence

Registration District No. 398 File No. 15989
 Primary Registration District No. 3019 Registered No. 101
 St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME John T. Downey

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED X
(Write the word)

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 3, 1914
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____, that I last saw h _____, 19____, and that death occurred, on the _____, stated above, at _____ m. The CAUSE OF DEATH* was as follows:

DATE OF BIRTH _____, 1____, _____, 1____, _____, 1____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS NAME OF FATHER John Downey BIRTHPLACE OF FATHER _____ MAIDEN NAME OF MOTHER _____ BIRTHPLACE OF MOTHER _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. McManamin (ADDRESS) Maywood Mo.

Filed May 4, 1914 F. L. Look REGISTRAR

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) _____ M. D. _____, 19____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death? _____ Former of usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 19____

UNDERTAKER _____ ADDRESS _____

Satisfactory information supplied.
 Satisfactory information supplied.
 Satisfactory information supplied.
 Satisfactory information supplied.

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