

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

Do not use this space.

21454

2589

1. PLACE OF DEATH  
 County Jackson Registration District No. 399  
 Township Kaw Primary Registration District No. 1003  
 City K.C.M. (No. Research Hoop) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME George Downs  
 (a) Residence. No. Brookfield, Mo. St. 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. 20 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male  
 4. COLOR OR RACE White  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 14 - 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
72 3 25

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

10. NAME OF FATHER John Downs

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

12. MAIDEN NAME OF MOTHER Budget

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

14. INFORMANT Mrs. Anna Downs  
 (Address) Brookfield, Mo.

15. FILED 6/9 1929 M. M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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 16. DATE OF DEATH (MONTH, DAY AND YEAR) June 9 1929

17. I HEREBY CERTIFY, That I attended deceased from 5-19, 1929 to 6-9, 1929, that I last saw him alive on 6-9, 1929, and that death occurred, on the date stated above, at 4 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Arteriosclerosis  
137  
152 (duration) yrs. mos. 30 mins. ds.  
 CONTRIBUTORY (SECONDARY) Prostate  
 (by period by Prostate) (duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

1. DIED IN OPERATION PRECEDE DEATH? Yes DATE OF 6/4/29  
 WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) Walter Halbrook M. D.  
6/9 1929 (Address) 816 Backrop

\*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 Brookfield, Mo. DATE OF BURIAL June 11 1929

20. UNDERTAKER D. W. Newcomer Sons ADDRESS K.C.Mo.

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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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