

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

Do not use this space.

37380

1. PLACE OF DEATH

County Jackson
 Township Kaw
 City Kansas City

Registration District No. 399
 Primary Registration District No. 1
 (No. St Larvs' Hosotial)

File No. _____
 Registered No. 4850
 St. _____ Ward _____

2. FULL NAME Miss Josephine Downing

(a) Residence. No. 4520 Madison 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) AUG 15 1886

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
43 3 10

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)

(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Timothy Downing

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

12. MAIDEN NAME OF MOTHER Mary Murphy

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

14. INFORMANT Mrs H E Erwin
 (Address) 4520 Madison

15. FILED 11/26 29 M. M. Erwin
 19. _____ REGISTRAR Arer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 25 1929

17. I HEREBY CERTIFY, That I attended deceased from 11-1-29 19. to Nov 25 1929 that I last saw him alive on Nov 23 1929 and that death occurred, on the date stated above, at 5 P. M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Chronic Cholelithiasis, Cholelithiasis & Common duct obstruction.

(duration) many yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Multiple abscesses of the liver (duration) 25 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Her home
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF _____
 WAS THERE AN AUTOPSY? yes

WHO TEST CONFIRMED DIAGNOSIS? Laboratory & Clinical with autopsy done M. D.
 (Signed) Dr. J. H. ...

11-26 1929 (Address) 914 Arroyo Blvd

*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 St. Marys Cemetery DATE OF BURIAL Nov 27 1929

20. UNDERTAKER Quirk & Tobin ADDRESS 20 West Lincoln

WRITE PAINLY, 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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