

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson **NOV 14 1939**
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1408 West 24th Street **2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 years (Specify whether years, months or days)
In this community 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1408 West 24th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME JOHN DOWNS 520
(b) If veteran, name war WW (c) Social Security No. no

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased No Record
(Month) (Day) (Year)

8. AGE: Years 61 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace Ireland
(City, town, or county) (State or foreign country)

10. Usual occupation Saloon Keeper

11. Industry or business _____

MOTHER FATHER { 12. Name Frank Downs
13. Birthplace Ireland
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Elizabeth Cotter
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Susan O'Brien
(b) Address 5724 Olive

17. (a) Burial (b) Date thereof 10-4-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Quize & Cohen Co
(b) Address Kansas City, Mo

19. (a) 10/2/39 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 10-2-39
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from 6:00 A.M.
to _____, 19____, to _____, 19____;
I saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Pulmonary embolism
Shic thrombosis (left)
Varicose veins (left)
Duration 11 1/2
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations ✓
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City, town, or county) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place) _____
(e) Means of injury _____

While at work _____
23. Signature Victor H. Reiter (M. D. or other) !
Address K.P. Ave Date signed _____

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.

WRITE LEGIBLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

I 19351

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Maurice M Quirk

Licensed Embalmer No. 2226

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.