

32873

FILED JAN 30 1943  
Registration District No. **1002**

Primary Registration District No. **1002**

1. PLACE OF DEATH:  
(a) County **Jackson**  
(b) City or town **Kansas City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution **St Joseph Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 week**  
(Specify whether  
In this community **30 yrs**  
years, months or days)

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. **2447** **Denver**  
(If rural, give location)  
(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country.

3. (a) PRINT FULL NAME **Eva Downey**  
3. (b) If veteran, name war **no**  
3. (c) Social Security No. **487-01-7524**

4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Harry Downey**  
6. (c) Age of husband or wife if alive **70** years  
7. Birth date of deceased **Feb 12 1890**  
(Month) (Day) (Year)

8. AGE: Years **51** Months **50** Days **11** 12  
If less than one day Ar. min.

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

10. Usual occupation **Clerk**

11. Industry or business **Eveready Shain Co**

MOTHER FATHER  
12. Name **Short**  
13. Birthplace **No Record**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Kella**  
15. Birthplace **No Record**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Vincent C Downey**

(b) Address **2447 Denver**

17. (a) **Removal** (b) Date thereof **Jan 16 1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Rushville Mo**

18. (a) Signature of funeral director **Mr C R Foster**

(b) Address **914 Brighton**

19. (a) **1-15-43** (b) **M. D. Brown**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **14**  
year **1943** hour **3** minute **40** P.M.

21. I hereby certify that I attended the deceased from **Jan 8** 19**43** to **Jan 14** 19**43**  
that I last saw him alive on **Jan 14**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Brain Tumor**  
Duplicat: **no record**

Due to **no record**  
Due to **no record**

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations **Brain Tumor**  
Of autopsy **Brain Tumor**  
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 or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **William M. North** (M. D. or other) **MD**  
Address **617 Professional** Date signed **1/15/43**

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

No. 0336

1-5-

Prof. Bledy

Dr. H. B. ...

**STATEMENT BY LICENSED EMBALMER**

*me*

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

*C. H. Wise*

Licensed Embalmer No.

*7570*

P. O. Address

*Kansas City*

**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 218

1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Joe Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME: Eva Downey

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex: fe 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
51

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

10. Usual occupation.....  
11. Industry or business.....

MOTHER FATHER  
12. Name.....  
13. Birthplace..... (City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)  
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
(b) Address.....

19. (a) 1/15/43 (b) m. m. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town.....  
(If outside city or town limits write "RURAL")  
(d) Street No. 2447 Denver  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: Month Jan day 14  
year 1943 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19..... to....., 19.....;  
that I last saw him..... alive on....., 19.....;  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Due to Hemorrhagic Endothelium  
Due to JA

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy: Hemorrhagic Endothelium

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 or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work..... (Specify type of place)  
(e) Means of injury.....  
23. Signature William M. Keith (M. D. or other) MD  
Address 611 Professional Bldg Date signed 2/9/43

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

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1053