

Registration District No. 149 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 6 weeks
(Specify whether years, months or days)
 In this community 61 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME THOMAS F. DOWD

3. (b) If veteran, name war No 3. (c) Social Security No. None

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 December ? 1881
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>6</u>	<u>3</u>	<u>-</u>
				hr. _____ min.

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

10. Usual occupation District Fire Chief

11. Industry or business Kansas City Fire Dept.

12. Name Jeremiah

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

14. Maiden name Fannie O'Grady

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

16. (a) Informant Robert J. Dowd

(b) Address 4032 Locust Street

17. (a) Burial (b) Date thereof 3/13/1944
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Quirk and Robin Co.
(b) Address 20 West Linwood Blvd., K.C., Mo.

19. (a) 3-11-44 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

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. 4032 Locust Street
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9th
year 1944 hour 2:30 minute P.M.

21. I hereby certify that I attended the deceased from _____ to _____
that I last saw him alive on 3/9/44 and that death occurred on the date and hour stated above.

Immediate cause of death:
Subacute bacterial meningitis, terminal
Perforated colon
Carcinoma of colon

Due to _____
 Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Duration
2 day
3 weeks
6 mos.

Major findings:
 Of operations _____
 Of autopsy _____

PHYSICIAN

 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?

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

23. Signature William M. Smith (M. D. or other) _____
Address 611 Professional Bldg. Date signed 3/10/44

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

MOTHER FATHER

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 Charles M. Quirk

Licensed Embalmer No. 3774

P. O. Address Kansas City, 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, fact should be so stated above.