

S. No. 2
OM-2-43
v. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF HEALTH STATISTICS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1061

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 140

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:
5712 St. John
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 31 years (years, months or days)

3. (a) PRINT FULL NAME Glenn LeRoy Downs

3. (b) If veteran, name war - no

3. (c) Social Security No. 487-05-2715

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

6. (b) Name of husband or wife Hazel 6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased March 13 1915
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>31</u>	<u>9</u>	<u>26</u>	<u>15</u> hr. <u>5</u> min.

9. Birthplace 302 Barat Kansas City, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Off set Pressman

11. Industry or business unemployed

12. Name Orin G. Downs

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

14. Maiden name Mary Thompson

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

16. (a) Informant Hazel Downs

(b) Address 5712 St. John

17. (a) burial (b) Date thereof January 11 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director C.H. Blackman & Son, Inc.

(b) Address 2825 Independence Blvd.

19. (a) 1-11-47 (b) Steraldine Holman
(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. 5712 St. John
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 8
year 1947 hour 8 minute 25 p.m.

21. I hereby certify that I attended the deceased from Nov 2
1946, to Jan 8 1947
that I last saw him alive on Jan 8 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Ventricular fibrillation
Due to Acute endocarditis 2 wks

Due to Acute polyarthritis
polyarthritic rheumatic fever 2 mo.
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations 926
Of autopsy _____

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? 2

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

23. Signature Virgil L. Hawkins (M. D. or other) MD
Address Independence Mo Date signed Jan 9 1947

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr. Hawkins

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 *H. D. Blackman*

Licensed Embalmer No. *3639*

P. O. Address *N. 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, fact should be so stated above.