

No. 2
-12-45
-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 1 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9020
Registrar's No. 1231

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:
General Hospital No. 1 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 mos. 8 days
(Specify whether
In this community 56 yrs
years, months or days)

3. (a) PRINT FULL NAME Frank Dowd
3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Males 5. Color or race W 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 Dec 6 1870
(Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days 219 If less than one day
hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name James Dowd 4
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Mary Hughes
15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Joe Dowd

(b) Address Wadsworth, Mo

17. (a) Burial (b) Date thereof 3-19-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Marys

18. (a) Signature of funeral director W. J. ...

(b) Address 143

19. (a) 3-18-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
Kansas City 3
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. 215 1/2 Indep. 8
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 16
year 1947 hour 7 minute 40 A.M.
21. I hereby certify that I attended the deceased from
Nov. 8 1946 to March 16 1947
that I last saw him alive on March 16 1947
and that death occurred on the date and hour stated above.

Immediate cause of death C. N. S. Lues
Bronchopneumonia
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 30 C
Major findings:
Of operations _____
Of autopsy None
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?
While at work? _____ (Specify type of place) (e) Means of injury 0
Signature Wm W. Ward (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 3-17-47

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

Dr Johnson

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..... *Peter B. Lazelle*
Licensed Embalmer No..... *H973*
P. O. Address..... *KLMO*

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.