

FILED JAN 5 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40898

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 5786

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas		b. COUNTY Crawford	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. LENGTH OF STAY (in this place) 7 months		c. CITY OR TOWN Pittsburg	
d. FULL NAME OF HOSPITAL OR INSTITUTION Little Sisters of the Poor		STREET ADDRESS (If rural, give location) Poor			

3. NAME OF DECEASED (Type or Print) a. (First) Charles		b. (Middle)		c. (Last) Downs		4. DATE OF DEATH (Month) (Day) (Year) Dec. 16, 1954	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH March 25, 1882	
9. AGE (In years last birthday) 72 years		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Lake Forest, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME James Downs		13b. MOTHER'S MAIDEN NAME Mary McVey		14. NAME OF HUSBAND OR WIFE -----	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME <i>Little Sisters of the Poor</i>		ADDRESS K.C. Mo.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 3 days	
		ANTECEDENT CAUSES DUE TO (b) Bronchial Asthma				20 yrs	
		DUE TO (c) Arterio sclerosis				26 yrs	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **3/19**, 19**54**, to **12/16**, 19**54**, that I last saw the deceased alive on **12/17**, 19**54**, and that death occurred at **6:30 p.m.** from the causes and on the date stated above.

23a. SIGNATURE OF REGISTRAR <i>Joseph A. Fogarty</i>		23b. ADDRESS 4501 Inman St. Bldg. 1316		23c. DATE SIGNED 12/18/54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Dec. 18, 1954		24c. NAME OF CEMETERY OR CREMATORY De. Smet, S.D.		24d. LOCATION (City, town, or county) (State)	
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DATE REC'D BY LOCAL REG 12-18-54		REGISTRAR'S SIGNATURE <i>Neve Marshall</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Thos. E. Quirk</i>		ADDRESS 4316 Troost Ave.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Thomas E. Jones

Licensed Embalmer No.
375

P. O. Address.....
A. E. J.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.