

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

357793
STATE FILE NUMBER
149 Primary Registration District No. 1002 Registrar's No. 4927

FILED NOV 14 1957

300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Robert L. Ward

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If inside corporate limits, give TOWNSHIP only) <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Belly Nursing Home</u> Length of stay in lb <u>13 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>4406 Indep. Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pollie</u> Middle <u>-</u> Last <u>DOWNING</u>			4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18-1874</u>
9. AGE (In years last birthday) <u>83</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>	
11. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		12. BIRTHPLACE (City and state or country) <u>Austin Kentucky</u>	
13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>John F. Witt</u>	
13b. MOTHER'S MAIDEN NAME <u>Bella Barry</u>		13c. NAME OF HUSBAND OR WIFE <u>George W. Downing Jr.</u>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) <u>No</u>		15. SOCIAL SECURITY NO. <u>-</u>	
16. INFORMANT <u>Mrs. Ruth Crockett</u>		17. ADDRESS <u>4406 Indep. Ave. K. C. Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Gall Bladder</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Cholecystitis - stones</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Atherosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>years</u> <u>584+</u>
19a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>July 53</u> to <u>10-22-57</u> and last saw her alive on <u>10-21-57</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert L. Ward, M.D.</u> (Degree or title)		22b. ADDRESS <u>4126 St John</u>	
22c. DATE SIGNED <u>10-24-57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>10-24-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>W. Washington Cem.</u>	
23d. LOCATION (City, town, or county) <u>Kansas City, Mo.</u>		23e. STATE <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>C. J. Blackman & Son Inc.</u> ADDRESS <u>A. C. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-24-57</u>	
26. REGISTRAR'S SIGNATURE <u>Irene Marshall</u>			

All diseases in Part I must be causally related.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.



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 *W. C. Quinn*

Licensed Embalmer No. *4879*

P. O. Address *K.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 embalmed by a STUDENT, he also shall sign in his OWN handwriting:

If this body is not embalmed, fact should be so stated above.