

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
James W. Downey

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 2 1958

58-014157

STATE FILE NUMBER 1854

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

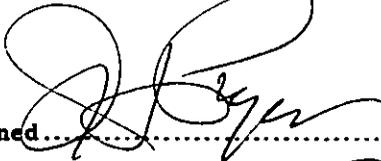
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hosp			Length of stay in hospital 44 yrs		d. STREET ADDRESS 3934 Washington (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First John Middle J. Last Downey				4. DATE OF DEATH Month 4 Day 10 Year 58					
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-24-88		9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Catholic Priest			10b. KIND OF BUSINESS OR INDUSTRY Our Lady of Good Counsel Church		11. BIRTHPLACE (City and state or country) County Kerry Ireland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James J. Downey				14. MOTHER'S MAIDEN NAME Mary Cahill					
15. WAS DECEASED EVER IN U. S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Finn Walsh, 432 W. 59 St. Mo.				Address K.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) mesenteric thrombosis								INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Cerebral thrombosis Rt.						1 MO	
		DUE TO (c) Paralysis left, Arterio Sclerotic Heart Disease						1 MO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterio Sclerotic Heart Disease; - 332X								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none							
20c. TIME OF INJURY Hour . Month, Day, Year a. m. p. m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from 2-7-58 to 4-10-58 and last saw ^{him} alive on 4-9-58 Death occurred at 6:10 A m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) James W Downey M.D.				22b. ADDRESS 425 E 63rd K.C. Mo.				22c. DATE SIGNED 4-11-58	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-12-58		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Mo.			
24. FUNERAL DIRECTOR Mellody-McGilley-Eylar K.C. Mo.				ADDRESS 20W. Linwood		DATE RECD. BY LOCAL REG. 4-11-58		26. REGISTRAR'S SIGNATURE Neve Winshall	



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em
by me, or by Student Embalmer No.
working under my personal supervision..

Student
Signature of Student Embalmer

Signed 
Licensed Embalmer No.

P. O. Address *KC*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.