

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED FEB 26 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

1425

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

410

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
outside city or town limits, write "RURAL" and name of township
 (c) Name of hospital or institution: St Joseph Hosp
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 Week - 3 days
(Specify whether)
 In this community Life
years, months or days

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. 3118 Wabash
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 27
 year 1940 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from Jan 25, 1940, to Jan 24 - 40;
 that I last saw him alive on Jan 24 - 40, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Pertussis
 Due to Intestinal obstruction
 Due to _____
 Other conditions None
(Include pregnancy within 3 months of death)

Duration

Major findings:
 Of operations as above
 Of autopsy Pertussis Pulmonary edema

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 None
 (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
 23. Signature Vincent J. Williams (M. D. or other)
 Address 736 Maple St Date signed Jan 27

3. (a) PRINT FULL NAME Dowling, Mrs. Agnes 452
 3. (b) If veteran, name war
 3. (c) Social Security No. 509-12-7952

4. Sex Fe 5. Color or race Wh
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife John Dowling
 6. (c) Age of husband or wife if alive 46 years
 7. Birth date of deceased Oct 1 1891
(Month) (Day) (Year)

8. AGE: Years 48 Months 3 Days 23
If less than one day hr. _____ min.

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

10. Usual occupation Mail - Diet Kitchen

11. Industry or business St Joseph Hosp

MOTHER FATHER
 { 12. Name John - Ireland
 { 13. Birthplace Ireland
(City, town, or county) (State or foreign country)
 { 14. Maiden name Mary Higgins
 { 15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Miss Mary Dowling
 (b) Address 3118 Wabash

17. (a) Burial (b) Date thereof Jan 29 40
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation mt Calvary

18. (a) Signature of funeral director P. A. Tinsley
 (b) Address Kans City Mo.

19. (a) Jan. 29, 1940 (b) M. M. Groves
(Date received local registrar) (Registrar's signature)

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MISSOURI BOARD OF HEALTH
DEPARTMENT OF HEALTH
DIVISION OF HEALTH SERVICES
ST. LOUIS, MISSOURI

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 

Licensed Embalmer No. 3203

P. O. Address.....

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1425
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No.
 (b) Township J.C. Primary Registration District No. Registered No. 410
 (c) City J.C. (d) Street No. St. Joseph Hosp St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Agnes Dowling
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>48</u>	<u>3</u>	<u>23</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 24, 1940

22. I HEREBY CERTIFY, That I attended deceased from to 19.....

I last saw him alive on 19..... Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:
Peritonitis -
Intestinal obstruction
perforated tumor

Other contributory causes of importance:
1220

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?

Date of onset

SUPPLEMENTARY

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19.....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 1/27 1940 M. M. Brown Local Registrar.

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify Cancer of Willium's M.D.
 (Signed) 126 Dryden
 (Address)

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