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

Do not use this space.

6671

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. Mo Bapt Hosp St. ..... Ward)

File No. 1493

Registered No. .....

2. FULL NAME Alan R. Downs

(a) Residence. No. 5547 Ashland ave. 6 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 20 1930

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	—	—	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Donald W. Downs

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Chicago
(STATE OR COUNTRY) Illinois

12. MAIDEN NAME OF MOTHER Velma Kraeger

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Missouri

14. INFORMANT Mr. Donald W. Downs
(Address) 5547 Ashland Ave

15. FILED ....., 19 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 17 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to February 11, 1930 that I last saw him alive on February 11, 1930 and that death occurred, on the date stated above, at 11.35 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-Pneumonia Primary
Acute Cardiac decompensation.
9 DB
107 A
130

..... (duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Acute Nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? yes.

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Thomas C. St. John, M. D.

, 19 (Address) Metropolitan Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Calvary Cemetery	2-12 1930
20. UNDERTAKER	ADDRESS
Geo. L. Pleitsch	5966 Easton ave.

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.

met [illegible]

7 to 8 O.M