

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

Do not use this space.

16230

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City.....
Hosp. John Downing City Hospital 1931
St. Ward)

2. FULL NAME

(a) Residence. No. 2100 St. 13 Ward. (If nonresident, give city or town and State)
(Usual place of abode) *Rock Hospital*
Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 17 - 1898*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
62 7 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Clerk 10¹⁵*
(b) General nature of industry, business, or establishment in which employed (or employer) *Terminal RR Bldg*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Spain*
(STATE OR COUNTRY)

10. NAME OF FATHER *Robert Downing*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *N. Y.*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Julia Traen*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Spain*
(STATE OR COUNTRY)

14. INFORMANT *W. H. ...*
(Address) *City Hospital*

15. FILED *APR 20 1931*
REGISTRAR *W. H. ...*

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 18 1931*

17. I HEREBY CERTIFY that I attended deceased from *June 8 1931* to *June 18 1931* that I last saw him alive on *June 18 1931* and that death occurred, on the date stated above, at *Rock Hospital*

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:

For Advanced Pulmonary Tuberculosis
116 (duration) 2 yrs. mos. ds.
CONTRIBUTORY *Stricture of Esophagus*
(SECONDARY) *(Gastrostomy done on 4-19-31)*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *Apr 19 1931*
WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *X ray*
(Signed) *DeW. Chargin*, M. D.

Apr 19 1931 (Address) *City Hospital*
*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 *Wachaea Cemetery* DATE OF BURIAL *4/20 1931*

20. UNDERTAKER *Meek 405 Dickman* ADDRESS *3039 Easton*

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A FEMALE MALE RECORD

Downing