

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.

NOV 23 1931

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

Do not use this space.

33865

1. PLACE OF DEATH
 County Cass Registration District No. 159
 Township Pack Primary Registration District No. 6-224
 City (No.) St. Ward

File No. _____
 Registered No. 10

2. FULL NAME Mortimer Downing
 (a) Residence, No. _____ St. _____ Ward. _____
 (Usual place of abode)
 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (write the word) <u>single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Day unknown 1855</u>		
7. AGE	YEARS <u>76</u>	MONTHS _____
	DAYS _____	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farmer</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____	
	10. Date deceased last worked at this occupation (month and year) <u>8/31</u>	11. Total time (years) spent in this occupation <u>always</u>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>New York</u>		
FATHER	13. NAME <u>Jim Downing</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>	
MOTHER	15. MAIDEN NAME <u>Mary Murphy</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>	
17. INFORMANT <u>Mrs. Jim Downing</u> (ADDRESS) <u>Strasburg Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Strasburg Cem</u> DATE <u>Oct 9 1931</u>		
19. UNDERTAKER <u>W. W. T. Lou</u> (ADDRESS) <u>Pleasant Hill, Mo</u>		
20. FILED <u>10/9 1931</u> <u>W. Beckman</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 7 1931

22. I HEREBY CERTIFY, That I attended deceased from 8-16, 1931, to 10-7, 1931
 I last saw him alive on 10-7, 1931. Death is said to have occurred on the date stated above, at 5:18 A.M.
 The principal cause of death and related causes of importance were as follows:
Myocardial insufficiency
 Date of onset Aug 1931

Other contributory causes of importance:
950
9510

Name of operation none Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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? no
 If so, specify _____
 (Signed) W. T. Beckman, M. D.
 (Address) Strasburg Mo.

