

AUG 11 1939

791

Registrar's No. **5968**

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

**1003**

(a) County \_\_\_\_\_  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 3607 Osceola  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution Home  
 (Specify whether  
 In this community Home  
 years, months or days)

3. (a) PRINT FULL NAME Infant Downing 552

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 6 1939  
 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day 8hrs hr. min.

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

10. Usual occupation Nil

11. Industry or business \_\_\_\_\_

12. Name James L. Downing

13. Birthplace Missouri  
 (City, town, or county) (State or foreign country)

14. Maiden name Grace Cassidy

15. Birthplace Missouri  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature George Cassidy

(b) Address 3607 Osceola St

17. (a) Burial (b) Date thereof July 7 1939  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Peetz Brothers

(b) Address 3029 Lafayette Ave

19. (a) JUL 6 1939 (b) J. B. Brubaker  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_  
 (c) City or town St. Louis **15**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3607 Osceola  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6 1939  
 year 1939 hour 12:30 minute 2 M.

21. I hereby certify that I attended the deceased from July 5, 1939 to July 6, 1939  
 that I last saw her alive on July 6, 1939  
 and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(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 Adrian Bone (M. D. or other) \_\_\_\_\_

Address 3115 S. Grand Blvd Date signed 7/6/39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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..... *Not Embalmed*

Licensed Embalmer No.....

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.**