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C23159

FILED JUN 20 1941

Registration District No. 1

Primary Registration District No. 200

Registrar's No. 157

1. PLACE OF DEATH:

(a) County Adair

(b) City or town RURAL
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution X
(Specify whether)

In this community LIFE
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Adair

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. near Green Castle
(If rural, give location)

(e) If foreign born, how long in U. S. A.? X years.

3. (a) PRINT FULL NAME ROBERT O DOWNEN

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

4. Sex MALE 5. Color or race W. 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased: FEB. 5 1855
(Month) (Day) (Year)

8. AGE: Years 86 Months 3 Days 17 If less than one day hr. min.

9. Birthplace Sullivan Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business FARM

12. Name JOE DOWNEN

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

14. Maiden name MARGARET OULFAY

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

16. (a) Informant Marion E Downen

(b) Address Green Castle Mo

17. (a) BURIAL (b) Date thereof 5 25 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GREEN CASTLE

18. (a) Signature of funeral director Glenn E Keel

(b) Address Green City Mo

19. (a) May 29/41 (b) Spencer L Freeman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23
year 1941 hour 2 minute 0 M.

21. I hereby certify that I attended the deceased from Jan 1941 to May 1941
that I last saw him alive on May 10 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis

Due to ✓

Due to ✓ 12/8

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

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 H. T. Garrison (M. D. or other)

Address Springer Mo Date signed 5-41

Duration: 5 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 10

District File Number 6-41-1179

Date Filed JUN 18 1941

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Greenville, S.C.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.