

Registration District No. **230**

Primary Registration District No. **4150**

Registrar's No. **26**

1. PLACE OF DEATH:

(a) County **DAVIES**
(b) City or town **CREATION MO.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **LIPE** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Madison**
(c) City or town **Lebanon**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **LESTER E. DOWNING**

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

4. Sex **M.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **ROBERTA** 6. (c) Age of husband or wife if alive **59** years
7. Birth date of deceased **SEPT 13 1879**
(Month) (Day) (Year)

8. AGE: Years **62** Months **1** Days **0** If less than one day hr. _____ min. _____

9. Birthplace **Davies County Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **MERCHANT**

11. Industry or business **GROCERY**

12. Name **GEO. W. DOWNING**

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

14. Maiden name **ROBERTA KNOWN**

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

16. (a) Informant **ROBERTA DOWNING**

(b) Address **CREATION MO.**

17. (a) **BURIAL** (b) Date thereof **10-14-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CREATION MO. BROWN**

18. (a) Signature of funeral director **STAN JONES**

(b) Address **CREATION MO.**

19. (a) **10-14-41** (b) **NO. HOPE**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **13th**
year **1941** hour **12⁰⁵** minute **:05A.M.**

21. I hereby certify that I attended the deceased from **12:00 A.M.**
October 13, 1941 to **October 13, 1941**
that I last saw him alive on **October 13, 1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion**

Due to **Cause undeterminable** Duration **10 min**

Due to **94N**

Other conditions **None Known**
(Include pregnancy within 8 months of death)

Major findings: **Not Indicated**

Of operations _____
Of autopsy **Not Done**

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 **C**

23. Signature **Robert A. Jones** (M. D. or other)
Address **CREATION MO.** Date signed **Oct 14 1941**

Duration

Signature

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 *C. M. Jones*
Licensed Embalmer No. *3453*
P. O. Address *Salisbury MD*

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, fact should be so stated above.