S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 21 1944

Registration District No. 3944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4259

Primary Registration District No. 6076

Registrar's No. 136

1. PLACE OF DEATH:

(a) County: St. Louis County

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

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

(d) Length of stay: In hospital or institution: Adm. Nov. 1, 1943 (Specify whether years, months or days)

In this community: unknown.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: St Louis

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

(d) Street No.: 544 South Clay St.,
(If rural, give location)

(e) Citizen of foreign country? - (Yes or No)

If yes, name country: -

3. (a) PRINT FULL NAME: Roy H. Downing

3. (b) If veteran, name war: World War #1

3. (c) Social Security No.: None.

4. Sex: Male

5. Color or race: white

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Helen

6. (c) Age of husband or wife if alive: 52 years

7. Birth date of deceased: May (Month) 10. (Day) 1888 (Year)

8. AGE: Years 55 Months 8 Days 7 If less than one day hr. min.

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

10. Usual occupation: Clerk

11. Industry or business: -

MOTHER FATHER

12. Name: Michael Downing

13. Birthplace: unknown (City, town, or county) Ireland (State or foreign country)

14. Maiden name: Mary Grogan

15. Birthplace: unknown (City, town, or county) Ireland (State or foreign country)

16. (a) Informant: M. Schully

(b) Address: Clinical Clerk, VAF, Jeff. Bks., Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: JAN. 19-'44 (Month) (Day) (Year)

(c) Place: burial or cremation: CALVARY CEM.

18. (a) Signature of funeral director: MICHAEL CROGHAN

(b) Address: 7146 MANCHESTER AVE.

19. (a) JAN 19 1944 (Date received local registrar) (b) E. D. McGavran, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 17th, year 1944 hour 7:15 minute A. M.

21. I hereby certify that I attended the deceased from Nov. 1, 1943, to January 17, 1944 that I last saw him alive on January 17, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral thrombosis with hemiplegia, right.	3 days
Due to: Due to Cerebral arteriosclerosis.	Unknown
Due to:	
Other conditions: Hypertensive and coronary arteriosclerotic heart disease with myocardial damage and myocardial insufficiency. (Include pregnancy within 3 months of death)	

Of operations: No operation.

Of autopsy: No autopsy.

PHYSICIAN: Unknown

Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify): no

(b) Date of occurrence:

(c) Where did injury occur?

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (City or town) (County) (State)

While at work: (Specify type of place) (e) Means of injury:

23. Signature: L. M. COCHRAN, M.D. (M. D. or other)

Address: Chief Medical Officer. Date signed: 1/17/44

(Licensed Embalmer's Statement on Reverse Side)

JAN 24 1944

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 Albert E. Lepp

Licensed Embalmer No. 2971

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, fact should be so stated above.