

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 3 1947

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 244

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

11
7

1. PLACE OF DEATH:

(a) County St. Joseph

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

(c) Name of hospital or institution: State Hospital # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 22 yrs 10 mos
(Specify whether years, months or days)

In this community 22 yrs. 10 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Joseph

(c) City or town Rural
(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 Anna B. Downs

3. (b) If veteran, name war 760

3. (c) Social Security No. 711

4. Sex Female

5. Color or race White

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

(b) Name of husband or wife Elvis Downs

(c) Age of husband or wife if alive not given years

7. Birth date of deceased May 7 1869
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 1947
year. 1947 hour 5:55 minute P M.

21. I hereby certify that I attended the deceased from Jan 21 1947 to 2-19 1947
that I last saw him alive on 2-19 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
with
respiratory
Due to arteriosclerosis
Duration 2 days
10 yrs

8. AGE: Years 77 Months 9 Days 13
If less than one day ----- hr. ----- min.

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

10. Usual occupation house work

11. Industry or business at home

12. Name William Downing

13. Birthplace Not given Not given
(City, town, or county) (State or foreign country)

14. Maiden name Mary Mathews

15. Birthplace not stated Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Schrick

(b) Address Maacavel Co Mo

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 2-21-47
(Month) (Day) (Year)

(c) Place: burial or cremation Cope cemetery - Weatherby, Mo

18. (a) Signature of funeral director Mrs Kate Stup

(b) Address Winston Mo

19. (a) 2-21-47 (Date received local registrar)

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy 108

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?

(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 W. Downing MD (M. D. or other)

Address State Hospital # 2 Date signed 1/19/47

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 L. O. Dickerson
Mrs. Kate Hoyle
Licensed Embalmer No. 3302

P. O. Address Winston, Mo.

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.

Gallatin, Mo.