

THE DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **10739**

BIRTH NO. **FILED APR 7 1954** REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **767**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Carsonville</b>		c. CITY OR TOWN <b>St. John</b> <b>4207</b>	
c. LENGTH OF STAY (In this place) <b>1 YEAR</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Penns Nursing Home</b>		e. STREET ADDRESS (If rural, give location) <b>8431 Ettrick Avenue</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Joseph</b>	b. (Middle) <b>Downing</b>	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <b>Mar. 26, 1954</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Feb. 21, 1875</b>	9. AGE (In years last birthday) <b>79</b>	# UNDER 1 YEAR Months <b>79</b> Days	# UNDER 2 HRS. Hours <b>79</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Little Rock, Ark</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Thomas H. Worley</b>	13b. MOTHER'S MAIDEN NAME <b>Ella Greenwell</b>	14. NAME OF HUSBAND OR WIFE <b>John D. Downing</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mary V. Bramstedt</b> ADDRESS <b>8431 Ettrick Ave.</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral thrombosis</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic cardiac vascular disease</b> DUE TO (c)		<b>unknown</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>arteriosclerotic dementia, Parkinson's disease</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>C. 4221</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Oct 4, 1952 to March 26, 1954**, that I last saw the deceased alive on **March 23, 1954**, and that death occurred at **3:50 P.M.** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Lewis Littmann M.D.</b> (Degree or title)	23b. ADDRESS <b>8231 Clayton Rd</b>	23c. DATE SIGNED <b>3/27/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>3-29-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Olney Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Olney, MO</b>
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DATE REC'D BY LOCAL REG. <b>3/27/54</b>	REGISTRAR'S SIGNATURE <b>Hebert R. Sankey</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Baumann Bros Inc</b> ADDRESS <b>2504 Woodson Rd Overland</b>
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WRITE PLAINLY—USING 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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Oscar F Mueller*

Licensed Embalmer No. 303

P. O. Address *Overland*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.