

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016320

STATE FILE NUMBER

AMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 149

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>	Length of stay in 1b <b>3 mo.</b>	c. CITY OR TOWN <b>Brashear</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <del>KIRKSVILLE</del> <b>Kirksville Osteopathic</b>		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>GROVER C. DOWNING</b>			4. DATE OF DEATH Month Day Year <b>May 30 1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/3/86</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and state or country) <b>Knox Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U S</b>
13a. FATHER'S NAME <b>Benjamin Downing</b>		13b. MOTHER'S MAIDEN NAME <b>Anna G. Cruse</b>		14. NAME OF HUSBAND OR WIFE <b>never married</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Wm. Downing, Brashear, Mo.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Medullary fracture</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Coronary artery occlusion</b>	
	DUE TO (c) <b>arteriosclerotic head disease</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>707</b>	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from 5-16-61 to 5-30-61 and last saw him alive on 5-30-61  
Death occurred at 9:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>[Signature]</i>		22b. ADDRESS <b>R.O. H. Kiensohke, Mo.</b>		22c. DATE SIGNED <b>5-31-61</b>
23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>	23b. DATE <b>6/2/61</b>	23c. NAME OF CEMETERY OR REINTERMENT <b>Brashear</b>	23d. LOCATION (City, town, or county) (State) <b>Brashear, Adair, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Foster Memorial Home, Kirksville, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>June 2, 1961</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DATE AMENDED

INSTEAD OF

DOCUMENT

DR.'S.S.I. MEDICAL CERTIFICATION per To

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

MISSOURI DEPARTMENT OF HEALTH

STATE OF MISSOURI

Name of Deceased

Sex

S. J. DE VITO, D.D.

Age

Place of Birth

Date of Birth

Place of Death

Sex

Place of Death

Date of Death

Place of Death

Sex

Signature of Licensed Embalmer

Signature of Student Embalmer

Signature of Student Embalmer

JUN 6 1960

JUN 6 1960

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  \_\_\_\_\_  
Nova E. Foster

Licensed Embalmer No. 4742

P. O. Address Kirksville, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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