

STANDARD CERTIFICATE OF DEATH

Registration District No. 249 Primary Registration District No. 6114 Registrar's No. 34

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1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Green City
(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 Life years, months or days _____

3. (a) PRINT FULL NAME Joel Lewis Johnson Downen
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lura Downen 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased October 7 1866
(Month) (Day) (Year)

8. AGE: Years 74 Months 1 Days 21 If less than one day _____ hr. _____ min.

9. Birthplace Sullivan County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Blacksmith

11. Industry or business Blacksmith Shop

12. Name Joel L. Downen

13. Birthplace Don't know Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Springer

15. Birthplace Don't know Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Hazel Morris

(b) Address Green City Missouri

17. (a) Burial (b) Date thereof 11-30-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green City Cemetery

18. (a) Signature of funeral director Alexander E. Reed

(b) Address Green City Mo.

19. (a) Dec 2-40 (b) Virginia Gibson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Sullivan
(c) City or town Green City
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 28 year 1940 hour 5 minute 0 P. M.

21. I hereby certify that I attended the deceased from Oct 6, 1940, to Nov 28, 1940, and that I last saw him alive on Nov 27, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Hemiplegia of Right Side
Due to being over heated digging in a ditch
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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? 771

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

23. Signature W. H. Thompson M.D. (M. D. or other) _____
Address Green City Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

0.5

FILED DEC 11 1940

30070
~~849~~
34

822
RECEIVED

District Health Officer No. 10

District File Number 12-40-3221

Date Filed DEC 7 1940

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 Archibald Wade

Licensed Embalmer No. 3057

P. O. Address Green City, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39970

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 849

Primary Registration District No. 6114

Registrar's No. 34

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

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Green City
(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.....
years, months or days)

3. (a) PRINT FULL NAME

Juel Leura Plinson Doumen

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 m
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year
7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 1 21 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(Burial, cremation, or removal)

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

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Registrar's signature)

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Nov day 28 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....; that I last saw h..... alive on..... 19..... and that death occurred on the date and hour stated above.

Immediate cause of death Hemiplegia right side Duration 8

Due to being overheated
digging in a ditch
Due to.....

Other conditions Central Hemorrh
(Include pregnancy within 3 months of death)

Major findings:
Of operations..... 82 h'
Of autopsy.....

PHYSICIAN

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).....

(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.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

1940

S-39970