No. 2
-13-40
-17-39
X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 27 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15676

Registration District No. 187 Primary Registration District No. 111 Registrar's No. 853

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Rich. Hgts.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St/Marys Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4days (Specify whether
In this community years, months or days)

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

3. (a) PRINT FULL NAME Downen, Anna
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife James
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 30 (Day) 1880 (Year)

8. AGE: Years 61 Months 10 Days 15 If less than one day hr. min.

9. Birthplace Jackson (City, town, or county) Ill (State or foreign country)
10. Usual occupation House Wife
11. Industry or business
FATHER
12. Name William Saul
13. Birthplace Dancaster (City, town, or county) England (State or foreign country)
MOTHER
14. Maiden name Sarah Robison
15. Birthplace Cleveland (City, town, or county) Ohio (State or foreign country)
16. (a) Informant E. J. Downen
(b) Address Jacob Ill,
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/17/42 (Month) (Day) (Year)
(c) Place: burial or cremation Glen H Hoppe,
18. (a) Signature of funeral director Albert H Hoppe
(b) Address 4700 Washington
19. (a) APR 17 1942 (Date received local registrar) (b) C. G. McGarran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15 year 1942 hour 12 minute 05 AM.
21. I hereby certify that I attended the deceased from 4/11/42, 19__, to 4/15, 1942 that I last saw her alive on 4/14, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Congestive heart failure	2 weeks
Due to hypertensive heart disease, myocarditis, nephritis	2 years
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Thomas C Budrace (M. D. or other)
Address 4660 Maryland Date signed 4/15/42

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. 15676
Registrar's No. 853

State of MO

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Richmond Heights (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: St Marys Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether years, months or days)
In this community

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

3. (a) FULL NAME Anna Downen
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife James
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May (Month) 30 (Day) 1880 (Year)

8. AGE: Years 61 Months 10 Days 15 If less than one day hr. min.

9. Birthplace _____ (City, town, or county) Ill (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace _____ (City, town, or county) England (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace _____ (City, town, or county) Ohio (State or foreign country)

16. (a) Informant's own signature
(b) Address
17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
(c) Place; burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month April day 15 year 1942 hour 12 minute 05 AM
21. I hereby certify that I attended the deceased from 4/11/42, 19__, to 4-15, 1942 that I last saw her alive on 4-14, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Congestive heart failure
Due to Hypertensive Heart disease myocarditis Nephritis
Due to 3 years
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration: 2 wks.
93d
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? _____ (Specify type of place)
While at work? _____ (e) Means of injury
23. Signature _____ (M. D. or other)
Address _____ Date signed MD

8-6917 U. S. GOVERNMENT PRINTING OFFICE 16—13493