WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Cape Girardeau

Township Welch

or

Village

or

City (NO. St.: Ward)

Registration District No. 122

Primary Registration District No. 5175

File No. 4006

Registered No. 7

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Hazel Austin

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Apr (Month) 20 (Day), 1901 (Year)

AGE: 14 yrs. 9 mos. 6 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: House work 8
(b) General nature of industry, business, or establishment in which employed (or employer): — 13

BIRTHPLACE (City or town, State or foreign country): Bollinger Co. Mo

PARENTS

NAME OF FATHER: John Austin

BIRTHPLACE OF FATHER (City or town, State or foreign country): Bollinger Co, Mo

MAIDEN NAME OF MOTHER: Emma Proctor

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Bollinger Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Austin

(ADDRESS) Whitewater Mo.

Filed Feb. 17, 1915. E. E. Higdon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb (Month) 6 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 6 2 Oclock P.M., 1915, to Jan 6 8 P.M., 1915, that I last saw her alive on Jan 6, 1915, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Auremic Poisoning following scarlet fever.

130 (Duration) ___ yrs. ___ mos. 1 ds.

Contributory (SECONDARY) ___ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. M. Finney M. D.

Whitewater Feb 7 1915 (Address) Whitewater Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Fairview Cemetery

DATE OF BURIAL: Feb 8, 1915

UNDERTAKER: J. M. Slagle

ADDRESS: Whitewater Mo

MISSOURI STATE BOARD OF HE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Revised United States Standard Certificate

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____, _____ St.: _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death o hospital or give its NA of street ani

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1_____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS
- NAME OF FATHER _____
- BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
- MAIDEN NAME OF MOTHER _____
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____
(Month) (Day

I HEREBY CERTIFY, that I attended dece _____, 191____, to _____ that I last saw h_____ alive on _____ and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos.

Contributory _____
(SECONDARY)
_____ (Duration) _____ yrs. _____ mos.

(Signed) _____

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent (
(1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRA RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURI
UNDERTAKER	ADDRESS