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

Do not use this space.

File No. 26836 B

Registered No.

1. PLACE OF DEATH
County Wright Registration District No. 911
Township Montgomery Primary Registration District No. 6227
City (No. St. Ward)

2. FULL NAME James M. Austin
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Shilda Austin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-18-1875

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53.	10	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER James Austin
11. BIRTHPLACE OF FATHER (CITY OR TOWN) do not Know
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Fanj Austin
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

14. INFORMANT Shilda Austin
(Address) Manes Mo.

15. FILED 9-20 1929 B L Johnston
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-23 1929

17. I HEREBY CERTIFY, That I attended deceased from 2-5, 1929, to 7-22, 1929, that I last saw h[illegible] alive on 5-25, 1929, and that death occurred, on the date stated above, at 6 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Endo Carditis
9ZA
(duration) 2 yrs. 6 mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) B. L. Johnston, M. D.
, 19 (Address) Manes

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Cope Cemetary	7-28-1929
20. UNDERTAKER	ADDRESS
N. L. Batten	Mt Grove Mo.

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.