

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

Do not use this space.

28704

**1. PLACE OF DEATH**

County St. Clair  
Township Scott  
City Louisy City (No. ....) St. .... Ward)

Registration District No. 763  
Primary Registration District No. 4458

File No. ....  
Registered No. 114

**2. FULL NAME**

William Franklin 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 Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah A. Austin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 11 1855

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.  
74 4 23

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

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

10. NAME OF FATHER John Austin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) .....

12. MAIDEN NAME OF MOTHER Louise Broyles

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) .....

14. INFORMANT W. H. Austin  
(Address) Louisy City, Mo.

15. FILED 9/20 1929 Lo S. Wright REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 4, 1929

17. I HEREBY CERTIFY, That I attended deceased from 3:00 July, 1929, to Aug 4, 1929, that I last saw him alive on Aug 4, 1929, and that death occurred, on the date stated above, at 7:30 P.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Paralysis

CONTRIBUTORY (SECONDARY) .....

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) E. S. Stall, M. D.  
Aug 5, 1929 (Address) Louisy City, Mo

\*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

Englewood Cemetery Aug. 5, 1929

20. UNDERTAKER ADDRESS

Austin Bros. Co. Louisy City, Mo

K. E. ... supplied. AGE ... that may be properly classified. ...

SEE ... 20 ...



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County St. Clair Registration District No. 763 File No. \_\_\_\_\_  
 Township Lowry City Primary Registration District No. 4438 Registered No. 14  
 City Lowry City (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward \_\_\_\_\_)

2. FULL NAME William Franklin 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 M  
 4. COLOR OR RACE W  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Virginia

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Virginia

14. INFORMANT \_\_\_\_\_  
 (Address) \_\_\_\_\_

15. FILED 8/20 1929 Leo S Wright REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 4 1929  
 17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ am.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Apoplexy or cerebral hemorrhage  
 (duration) \_\_\_\_\_ yrs. 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) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address) \_\_\_\_\_

\*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 \_\_\_\_\_ 19\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY RECORD

ADDITIONAL INFORMATION SHOULD BE CAREFULLY APPLIED. AGES AND SEXES SHOULD BE PROPERLY CLASSIFIED. EXACT OCCUPATION IS VERY IMPORTANT.

Every item of information should be carefully applied. AGES AND SEXES SHOULD BE PROPERLY CLASSIFIED. EXACT OCCUPATION IS VERY IMPORTANT. ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRY

5-28704

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CERTIFICATE OF DEATH**

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28705

**1. PLACE OF DEATH**

County St. Clair Registration District No. \_\_\_\_\_  
 Township St. Louis Registration District No. 4739  
 City St. Louis St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 11 mos. 7 da. How long in U.S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da. \_\_\_\_\_

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 28 1858

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	70	11	3	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work at Home  
 (b) General nature of industry, business, or establishment in which employed (or employer) Housekeeping  
 (c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) St. Clair Co., Mo.

**10. NAME OF FATHER**

James M. Gilliam

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Hartsville, Tenn.

**12. MAIDEN NAME OF MOTHER**

Sarah P. Terry

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Tenn.

14. INFORMANT Robert Turner  
 (Address) Ohio, Mo.

15. FILED \_\_\_\_\_, 19 \_\_\_\_\_ REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 31, 1929

17. I HEREBY CERTIFY That I attended deceased from Aug. 26, 1929, to Aug. 31, 1929, that I last saw her alive on Aug. 28, 1929, and that death occurred, on the date stated above, at 8 - P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

acute Gastritis

CONTRIBUTORY (SECONDARY) None (duration) yrs. \_\_\_\_\_ mos. 6 da. \_\_\_\_\_

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

**WHAT TEST CONFIRMED DIAGNOSIS:**

(Signed) R. J. Smith M. D.  
 , 19 \_\_\_\_\_ (Address) Applenton City

\*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 Terry Cemetery DATE OF BURIAL Sept. 1, 1929

20. UNDERTAKER Austin Bur. & Co ADDRESS Louis City, 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.

RECORDING INFORMATION—THIS IS A PERMANENT RECORD

93  
 67  
 11

262

state blood

READING IN  
should be careful  
so that it

ON

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Clair Registration District No. 261 File No. \_\_\_\_\_  
 Townshp. Monongah Primary Registration District No. 6014 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward \_\_\_\_\_)

**2. FULL NAME**

Sarah Francis Gilliam  
 (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. da. How long in U. S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(prior the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 28 - 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
70 89 3

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

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

10. NAME OF FATHER James M. Gilliam

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Hartsville Tenn

12. MAIDEN NAME OF MOTHER Sarah Terry

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn

14. INFORMANT Chas Turner  
 (Address) Ohio mo

15. FILED Nov 11 1929 W. Olive REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 31 1929

17. I HEREBY CERTIFY that I attended deceased from Aug 26 to Aug 31, 1929 that I last saw him alive on Aug 28, 1929, and that death occurred, on the date stated above, at 8 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
acute gastritis  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 6 ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) R. J. Smith M. D.  
 . 19 \_\_\_\_\_ (Address) Appleton City

\*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 Terry Cemetery DATE OF BURIAL Sept 1 1929

20. UNDERTAKER Austin Bros. & Co ADDRESS Lowry City mo

WRITE PLAIN 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-28705