

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

Do not use this space.

15554

**1. PLACE OF DEATH**

County Carroll  
Township Waverly  
City (No. ....) .....

Registration District No. 135  
Primary Registration District No. 5192

File No. ....  
Registered No. 45 St. .... Ward)

**2. FULL NAME**

E. L. Vivia Francis 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**

Female

**4. COLOR OR RACE**

White

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

Widowed

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

W. F. Austin

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

**7. AGE**

YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
69	1	27	

**8. OCCUPATION OF DECEASED**

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

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

Galina, Indiana

**10. NAME OF FATHER**

J. B. Mivins

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

Indiana

**12. MAIDEN NAME OF MOTHER**

Hazwood

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

Indiana

**14. INFORMANT (Address)**

Floy Austin Bogard Mo.

**15. FILED 5-22, 1930 Mrs. E. E. Farnham REGISTRAR**

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 5/21 1930

**17. I HEREBY CERTIFY, That I attended deceased from May 18 1930 to May 27 1930 that I last saw her alive on May 27 1930 and that death occurred, on the date stated above, at 3 p.m.**

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

Chronic Interstitial Nephritis

Probably (duration) 5 yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

(duration) ..... yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF BIRTH

8 DID AN OPERATION PRECEDE DEATH? DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? albumin  
(Signed) J. M. Wooden M. D.

5-22, 1930 (Address) Bogard 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**

Ebenzer

**DATE OF BURIAL**

527 1930

**20. UNDERTAKER**

E. D. Dickerson

**ADDRESS**

Bogard

Cause of death information should be carefully 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.

PROPERTY OF THE  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

**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 Carroll Registration District No. 135- File No. ....  
 Township Trotter Primary Registration District No. 5192 Registered No. 43-  
 City No. .... St. .... Ward)

2. FULL NAME Elwin Francis Austen  
 (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. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-24-1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
69 1 27

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)

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 5-22-1920 Lyne E E Farnham REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/21 1920

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....  
 (That I last saw b. .... alive on ..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
 CONTRIBUTORY (SECONDARY)  
 (duration)..... yrs. .... mos. .... da.

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

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.

SUPPLEMENTARY

3-100W