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

Do not use this space.

30449

1. PLACE OF DEATH
County Atchison Co — Registration District No. 19 — File No.
Township Plaza — Primary Registration District No. 4013 — Registered No.
City Rockport Mo (No. ..... St. ..... Ward)

2. FULL NAME Jim N. Austin
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
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.

OCT 22 1931

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1882-4-16

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
49	5	26	

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) Coin Iowa
(STATE OR COUNTRY) Iowa

PARENTS
10. NAME OF FATHER W. G. Austin
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Nancy Haner
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT Mrs. Austin
(Address)

15. FILED Sept 11 1931 Mary J. Chamberlain REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 11th 1931

17. I HEREBY CERTIFY, That I attended deceased from May 18 1931, to Sept 11th 1931, that I last saw him alive on Aug 27, 1931, and that death occurred, on the date stated above, at 3:30 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
82 A
117 A
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Gastric Ulcer
(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? None

(Signed) E. H. Lewis, M. D
, 19 (Address) Rock Port 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: Snow Hill - Coin Iowa
DATE OF BURIAL: Sept 13 1931

20. UNDERTAKER: C. E. Bertram
ADDRESS: Rockport Mo

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.