

8370 JUN 15 1939

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

18541
Do not use this space.

1. PLACE OF DEATH:
 (a) County Franklin Registration District No. 288
 (b) Township Independence Primary Registration District No. 5796 Registered No. _____
 (c) City _____ (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Infant Baby Austin
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 5 1929

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

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

13. NAME Ben Austin 9

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

15. MAIDEN NAME Kelma Cox

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

17. INFORMANT Ben Austin
(ADDRESS) 1234 1/2 St. R2

18. BURIAL, CREMATION, OR REMOVAL PLACE Methodist Episcopal Church DATE May 12 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Coffey Home

20. FILED 5-16 1939 Thule Davis Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-5 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Stillborn

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____

(Signed) Thule Davis, M. D.
 (Address) 1234 1/2 St. R2

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.

FORM-1-1-38

RECEIVED

District Health Officer No. 3,

District File Number 29-348

Date Filed 6/7/39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____

_____ or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.