

REC'D JUN 13 1939

## MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

18786

Do not use this space.

## 1. PLACE OF DEATH

(a) County Howell Registration District No. 384  
 (b) Township West Plains Primary Registration District No. 4227  
 (c) City West Plains, Mo Street No. Christa Hogen Hospital Registered No. \_\_\_\_\_  
 (d) Length of residence in city or town where death occurred yrs. mos. 21 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

(a) Residence, No. West Plains, Mo. P.F.D. St. Mo.  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX ma 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 29 - 1922  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
16 8 16

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Student  
 9. Industry or business in which work was done, as saw mill, bank, etc. Student  
 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) Howell Co. Mo.

13. NAME Fred J. Austine

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Plains, Mo.

15. MAIDEN NAME Ida M. Spears

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

17. INFORMANT (ADDRESS) Fred J. Austine  
West Plains, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Austine Cem. DATE 5/17 - 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Thompson  
West Plains, Mo.

20. FILED 6-7- 1939 Ida M. SIMONS  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/15 - 1939

22. I HEREBY CERTIFY, That I attended deceased from 4/25, 1939, to 5/15, 1939

I last saw him alive on 5/15, 1939 Death is said to have occurred on the date stated above, at 5A m.  
 The principal cause of death and related causes of importance were as follows:

Pulmonary Embolism Date of onset 5/15/39  
121

Other contributory causes of importance:  
General peritonitis from 4/19/39  
Ruptured appendix

Name of operation incision & drainage Date of 4/25/39  
 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) Maurice Thompson M. D.  
 (Address) West Plains, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

I X-16603

**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 George D. Robinson, Registered Apprentice No. \_\_\_\_\_ working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 3432

P. O. Address West Haven

**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.**