

NOV 9 1939 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

36210
Do not use this space.

1. PLACE OF DEATH *Holt.* Registration District No. *972*
 (a) County *Holt.* (b) Township *1*
 (c) City *Mound City* (d) Street No. *5518* Registered No. *1018*
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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 *Emaline Audus*
 (a) Residence, No. *500* St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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 *H.C. Audus, ora.*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept 29 1847*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 0 23
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *House work.*
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 22 1938*
 22. I HEREBY CERTIFY, That I attended deceased from *Jan 1*, 1939, to *Oct 22*, 1939
 I last saw her alive on *Oct 21*, 1939. Death is said to have occurred on the date stated above, at *8 A.M.*
 The principal cause of death and related causes of importance were as follows:
Coronary Artery Occlusion
 Date of onset
 Other contributory causes of importance: *A.H.*
 Name of operation _____ Date of _____
 What test confirmed diagnosis? *physical* Was there an autopsy? *no*
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? *no* 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? *no*
 If so, specify _____
 (Signed) *D.C. Perry*, M. D.
 (Address) *Mound City Mo*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Berks Co. Penn.*
 FATHER 13. NAME *John Schreffler.*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Berks Co Penn*
 MOTHER 15. MAIDEN NAME *Ellen N. Smith.*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Berks Co Penn*
 17. INFORMANT (ADDRESS) *W.P. Wightman Mound City Mo.*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Mt Hope* DATE *10-24 39*
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *W.J. Craunpaul Mound City Mo.*
 20. FILED *Nov 1 1939* *J. C. ...* Local Registrar.

WHITE 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.

Case No. 11, No. 11,
District File Number AD 39-1464
Date Filed 7 1939

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 *A. H. Crawford*
Licensed Embalmer No. 1824
P. O. Address *Mound City Mo.*

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.