DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 3 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2192

29 Registration District No. 257 Primary Registration District No. 4146 Registrar's No.

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.

1. PLACE OF DEATH:

(a) County Dade

(b) City or town So Greenfield Mo

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dade

(c) City or town So. Greenfield Mo

(If outside city or town limits, write "RURAL")

(d) Street No. Missouri

(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Nancy Austin

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife Lawrence Austin

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb (Month) 8 (Day) 1863 (Year)

8. AGE: Years 76 ~~66~~ Months 10 Days 13 If less than one day hr. min.

9. Birthplace Indiana (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business

FATHER 12. Name Alexander Brown

13. Birthplace not known (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name Not known

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Leonard Austin

(b) Address So Greenfield Mo

17. (a) (Burial, cremation, or removal) (b) Date thereof 12-22-39 (Month) (Day) (Year)

(c) Place: burial or cremation Pennsboro, Mo.

18. (a) Signature of funeral director J. O. Ward

(b) Address Greenfield, Mo.

19. (a) 1-16-1940 (Date received local registrar) (b) Geo. L. Weis (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 21 day year 1939 hour 6 P M minute M.

21. I hereby certify that I attended the deceased from Dec 15, 1939 to Dec 21, 1939 that I last saw her alive on Dec 21st, 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial Pneumonia	7
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature L. D. Holmes (M. D. or other)

Address Miller Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 140-273
Date Filed JAN 25 1940

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.....

J. W. Ward, Registered Apprentice No.....

working under my personal supervision.

Signed J W Ward

Licensed Embalmer No. 2832

P. O. Address Greenfield Mo

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

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

o. 2B
-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2122

Registration District No. 237

Primary Registration District No. 4146

Registrar's No.

1. PLACE OF DEATH
(a) County
(b) City or town Greenfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Nancy Austin
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) April 3-1940 (Date received local registrar) Geo. L. Weis (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 21
year 1939 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations
Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature L. J. Holmes (M. D. or other)
Address Milan Mo Date signed

SUPPLEMENTARY