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

RECEIVED 16 1940

6425
Do not use this space.

1. PLACE OF DEATH
(a) County Dallas
(b) Township Grant
or
(c) City
Registration District No. 242
Primary Registration District No. 5335
Registered No.
(d) Street No. St.
(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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 235 Ida Alice Austin
(a) Residence, No. Dallas Co Buffalo St.
(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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF: Luther Austin

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 1-26-1880

7. AGE: Years 60 | Months | Days 16 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: House wife
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

FATHER
13. NAME: Jno Wise
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): O

MOTHER
15. MAIDEN NAME: Catherine Jump
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo O

17. INFORMANT (ADDRESS): Luther Austin Louisburg Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Lindley Cem. DATE 2-14 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS): L. B. Jones Buffalo Mo.

20. FILED 3-5-1940 Mrs J R Cox Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-12 1940

22. I HEREBY CERTIFY, That I attended deceased from 2- 1937, to 2-12 1940
I last saw her alive on 2-12 1940. Death is said to have occurred on the date stated above, at 5:30 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Endocarditis Infective (Chronic)	2-1937
due to Gram Blood stream infection	

Other contributory causes of importance: None

Name of operation none Date of
What test confirmed diagnosis? Clinical Was there an autopsy? no

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 none
Nature of injury none

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) Claude A. Hennon, M. D.
(Address) Buffalo 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 X1860

AUG 26 1953

AUG 24 1953

RECEIVED
District Health Officer No. 7
District File Number 3-40-439
Date Filed 3-11-40

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 compl with the above constitutes grounds for revocation of license.)

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

No. 2B
-2-21-40
I 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. 6425

Registration District No. 242 Primary Registration District No. 2335 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH

(a) County Dallas

(b) ~~City or town~~ Grant Twp (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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas

(c) City or town Rural (If outside city or town limits write "RURAL")

(d) Street No. Near Buffalo (If rural give location)

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

3. (a) PRINT FULL NAME Ida Alice 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 m

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 60 Months Days 16 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 Dallas Co. Mo (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) 3-8 1940 (Date received local registrar) (b) Miss J R Cox (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 13 year 1940 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)	
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 Claude O. Gammon
Address Buffalo Mo signed