

Registration District

JUL 9 1940

Primary Registration District No.

3038

Registrar's No.

98

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall

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

(c) Name of hospital or institution: Fitzgibbon

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

(d) Length of stay: In hospital or institution 1 day

(Specify whether years, months or days)

In this community 67 yr

3. (a) PRINT FULL NAME HORACE A AUSTIN 20c

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased July - 3 1855

(Month) (Day) (Year)

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

84 11 10 hr. min.9. Birthplace Boonville, Mo. (City, town, or county) (State or foreign country)10. Usual occupation Tinsmith

11. Industry or business _____

12. Name Arcie A. Austin13. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)14. Maiden name Caroline Austin15. Birthplace Madison (City, town, or county) (State or foreign country)16. (a) Informant's own signature Al Austin(b) Address Clairville, Iowa17. (a) Burial (b) Date thereof June 15 - 1940(Burial, cremation, or removal) Edge Park Marshall Mo (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Harry Hershberger(b) Address Marshall Mo19. (a) 6-15-40 (b) Mary Kent

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline

(c) City or town Marshall

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

(d) Street No. So Jefferson

(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13 - 1940year 12:00 noon hour minute M.

21. I hereby certify that I attended the deceased from

June 12 1940 to June 13 1940that I last saw him alive on June 13 1940

and that death occurred on the date and hour stated above.

Immediate cause of death Fracture and dislo-cation 1st and 2nd cervical ver-tebrae caused by accident. Duration _____Due to fall resulting of automobileaccident as he was returning fromDue to trip to Iowa on June 8, 1940Do not know whether it occurredOther conditions in Iowa or Missouri

(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) Accident(b) Date of occurrence June 8, 1940(c) Where did injury occur? Do not know

(City or town) (County) (State)

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

As aboveWhile at work? no (Specify type of place) (e) Means of injury As above23. Signature J. Manning (M. D. or other) _____Address Marshall, Mo Date signed 6-15-40

210 m

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 7-11-40

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 B W Campbell
Licensed Embalmer No. 3469
P. O. Address Marshall, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22922**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **796**

Primary Registration District No. **3038**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Saline**
(b) City or town **Marshall**
(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

3. (a) PRINT FULL NAME **Horace Austin**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, divorced, married **s**

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 **84** Months **11** Days **10** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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.

DECEASED CERTIFICATION

20. DATE OF DEATH: Month **June** 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.

Immediate cause of death: **Fracture and Dislocation of 1st and 2d Cervical Vertebrae**
Due to: **Carried by accident of Wrecking of Automobile**
Due to: **Non collision, skidding automobile turning on wet pavement**
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____
Of operations: **2.10 m 28**
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?

While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature **D. A. Manning** (State or other) _____
Address **Marshall** State signed _____

SUPPLEMENTARY

S-22922