No. 2
11-10-39
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

NOV 16 1940

Registration District No. 791

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 33696

Registrar's No. 8393

FILED

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 mos 4 days
(Specify whether
In this community 2½ years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 1811 a Goode
(If rural, give location)

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

3. (a) PRINT FULL NAME Bessie Austin

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Femal

5. Color or race Colord

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

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

6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased Dec. 17 - 1917
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
22 ~~1917~~	9	14	hr. min.

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

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name Ford Beasley
13. Birthplace Liberty Mississippi
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth Royster
15. Birthplace Marianna Ark.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Eulah Shorter

(b) Address 1811 A Goode Ave.

17. (a) Shipped (Burial, cremation, or removal) (b) Date thereof Oct 10. 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Marianna Ark.

18. (a) Signature of funeral director Adams Undertaker

(b) Address 3849 Windsor Place.

19. (a) 10-9-40 (Date received by local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 4
year 1940 hour 11:45 minute P M.

21. I hereby certify that I attended the deceased from April 30, 1940 to October 4, 1940; that I last saw her alive on October 4, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	1 year
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 Edell W. Dutch (M. D. or other)

Address 2601 N Whittier Date signed 10/7/40

(Licensed Embalmer's Statement on Reverse Side)

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. 2963

P. O. Address 2915 Franklin

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.