

FILED AUG 29 1941

Registration District No. **384**

Primary Registration District No. **4227**

1. PLACE OF DEATH:

(a) County **Howell**
(b) City or town **West Plains,**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Christa Hogan Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **87 days**
21 years (Specify whether
in this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Howell**
(c) City or town **RURAL Howell Twp.**
(If outside city or town limits, write "RURAL")
(d) Street No. **West Plains, Mo. Lebo Rt.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** 9 day
year **1941** hour **3** minute **30** P. M.

21. I hereby certify that I attended the deceased from
July 2 1941 to **July 8** 1941;
that I last saw him alive on **July 9** 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cause of fracture and fracture**
Duration _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **W. H. Simon** (Name of other) _____
Address **West Plains, Mo.** Date signed _____

3. (a) PRINT FULL NAME **PIKE CARLOSS AUSTIN**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Kate Cuppy Austin** 6. (c) Age of husband or wife if alive **81** years

7. Birth date of deceased **January 26, 1855**
(Month) (Day) (Year)

8. AGE: Years **86** Months **5** Days **13**
If less than one day _____ hr. _____ min.

9. Birthplace **Buffalo, N.Y.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Own Farm**

12. Name **Clark C. Austin**

13. Birthplace **Buffalo, N.Y.**
(City, town, or county) (State or foreign country)

14. Maiden name **Rosalinda Wheeler**

15. Birthplace **Buffalo, N.Y.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Kate C. Austin**

(b) Address **West Plains, Mo. Lebo Rt.**

17. (a) **Burial** (b) Date thereof **July 11, '41**
(Burial, cremation, or removal) (Month) (Day) (Year)
Oaklawn Cem.

(c) Place: burial or cremation **West Plains, Mo.**

18. (a) Signature of funeral director **W. H. Simon**

(b) Address **West Plains, Mo.**

19. (a) **7-10-41** (b) **W. H. Simon**
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 5,

District File Number 8811899

Date Filed

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. 3408

P. O. Address West Plains

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28460
Registrar's No.

Registration District No. 384

Primary Registration District No. 4227

1. PLACE OF DEATH:

- (a) County Hovell
(b) City or town West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Christa Hogan Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 21 yrs (Specify whether
In this community 21 yrs years, months or days)

3. (a) PRINT
FULL NAME

Pike Carlross Austin

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 m

6. (b) Name of husband or wife

6. (c) Age of husband or wife if

alive 185 years

7. Birth date of deceased

Jan 26, 185 (Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

86

5

5

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

(City, town, or county)

(State or foreign country)

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)

(Date received local registrar)

(b)

(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) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9
year 1941 hour 10 minute 00 M.

21. I hereby certify that I attended the deceased from 19.....
that I last saw him alive on 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death

Cancer of prostate
and bladder

Due to Primary heart of
growth prostate
and bladder

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 518

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 W. A. ... (Date or other)
Address West Plains Day signed

06430-41

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

SUPPLEMENTARY

S-28460