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

10106
Do not use this space.

FILED APR 15 '43

1. PLACE OF DEATH — 1DD
(a) County Dent
(b) Township Texas
(c) City
Registration District No.
Primary Registration District No. 5391 33
Registered No. 107
(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 Louis M. Austin
(a) Residence, No. 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 M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~ HUSBAND OF (OR) ~~WIFE OF~~ Emma Austin
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 25, 1851
7. AGE — YEARS 92 — MONTHS — DAYS 19 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farming
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) June 1926
11. Total time (years) spent in this occupation 70

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Decator Ill.

FATHER
13. NAME William Austin
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Amherst Co. Va.

MOTHER
15. MAIDEN NAME Elnor Woonick
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not Known Tenn.

17. INFORMANT (ADDRESS) Susan Scott Rhyse Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Williams Cem. DATE 3-17-43
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Smith Ferguson Licking Mo
20. FILED 3-17-43 19.... J. S. Rucker Local Registrar.

1177

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 16 1943
22. I HEREBY CERTIFY, That I attended deceased from Dec 1941, to Mar 16 1943
I last saw h... alive on ..., 19.... Death is said to have occurred on the date stated above, at 6:15 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Fractured hip (Left)	
Surgical Neck	

Other contributory causes of importance:

Nephritis Chronic	

Name of operation ... Date of ...
What test confirmed diagnosis? ... Was there an autopsy?

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 ...
Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ...
If so, specify ...
(Signed) Leslie Campbell, M. D.
(Address) Licking Mo

(Licensed Embalmer's Statement on Reverse Side)

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.

THIS IS A PERMANENT RECORD

1 X14928

RECEIVED
District Health Officer No. 5,
District File Number 443235
Date Filed 4-16-42

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, ...
Not Embalmed, or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Cuber K. Ferguson

Licensed Embalmer No. 3945

P. O. Address Licking 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.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10106

Registration District No. 100 Primary Registration District No. 3-39 1 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Dent
(b) City or town Rural Salem
(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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Louis N. 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 W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb 21 1851
(Month) (Day) (Year)

8. AGE: Years 92 Months — Days If less than one day hr. min.

9. Birthplace (City, town, or county) Ill. (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) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.
Immediate cause of death Fractured hip
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) accident
(b) Date of occurrence 12-19-42
(c) Where did injury occur? Cumberland (City or town) Dent (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home (Specify type of place)
While at work? no (e) Means of injury fell

23. Signature Luther Crandall (M. D. or other)
Address Licking Mo Date signed