

FILED OCT 13 1945

Registration District No. _____

Primary Registration District No. **4096**

1. PLACE OF DEATH:

- (a) County **Cass**
(b) City or town **Freeman Mo.**
(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

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

- (d) Length of stay: In hospital or institution _____ (Specify whether)

In this community **7 years**
years, months or days

3. (a) PRINT FULL NAME **MAYME ADALINE AUSTIN**

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

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Herbert Austin** 6. (c) Age of husband or wife if alive **73** years

7. Birth date of deceased **Oct. 25 1880**
(Month) (Day) (Year)

8. AGE: Years **62** Months **9** Days **9** If less than one day hr. _____ min.

9. Birthplace **Whitehouse Kans.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business _____

- MOTHER FATHER { 12. Name **William L. White**
13. Birthplace **Lexington Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Eliza Goodrich**
15. Birthplace **Un Known**
(City, town, or county) (State or foreign country)

16. (a) Informant **Kathryn E. Newell**

- (b) Address **Kansas City Mo. 3908 Forest**

17. (a) **Freeman Mo.** (b) Date thereof **Oct 5-1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation **Freeman Mo.**

18. (a) Signature of funeral director **Geo F. Myers**

- (b) Address **Cleveland 225 E. 11**

19. (a) **Oct. 5, 1943** (b) **Margaret Velle**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Missouri** (b) County **Cass**
(c) City or town **Freeman**
(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.? **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **OCT.** day **4th.**
year **1943** hour **12:55** minute **P. M.**

21. I hereby certify that I attended the deceased from **Sept. 27**
19**42**, to **Oct. 4**, 19**43**

that I last saw her alive on **OCT. 4**, 19**43**

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

Immediate cause of death **CIRCULATORY FAILURE**

Due to **Cerebral Hemorrhage**

Due to _____

Other conditions **83a**
(Include pregnancy within 3 months of death)

Major findings of operations _____

Of autopsy _____

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 **PAUL H. Green** (M. D. or other) **D.O.**

Address **Harrisonville, Mo.** Date signed **Oct. 5, 1943**

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 Geo. E. Myers

Licensed Embalmer No. 2517

P. O. Address Cleveland 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.