

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

5512  
Do not use this space.

**FILE** MAR 8 1945

**1. PLACE OF DEATH**

(a) County Bonnie Registration District No. 4-D  
 (b) Township Rockyfork Primary Registration District No. 4051  
 or Hallsville  
 (c) City Hallsville (d) Street No. 1 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 79 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

BENJAMIN PARKER AUSTENE  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Julia Ann Austene  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_  
 7. AGE YEARS 79 MONTHS 11 DAYS 7 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Carpenter  
 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) \_\_\_\_\_ 11. Total time (years) spent in this occupation 60 yrs  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hallsville Mo.  
 FATHER 13. NAME Benjamin P. Austene  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maryland  
 MOTHER 15. MAIDEN NAME Susan Stubblefield  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky  
 17. INFORMANT B. P. Austene, Dec. (ADDRESS) Hallsville Missouri  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Zion Cem. DATE Feb. 26, 1945  
 19. FUNERAL DIRECTOR (NAME) Parker Funeral Service (ADDRESS) Columbia Missouri  
 20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 24, 1945  
 22. I HEREBY CERTIFY, That I attended deceased from 3-31-44, 19\_\_\_\_, to 2-23-45, 19\_\_\_\_  
 I last saw him alive on 2-23-45, 19\_\_\_\_. Death is said to have occurred on the date stated above, at home.  
 The principal cause of death and related causes of importance were as follows:  
Cerebral Hemorrhage  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: Hypertension  
Atherosclerosis  
Chronic Glomerular Nephritis  
 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? No  
 If so, specify \_\_\_\_\_  
 (Signed) B. P. Austene, M.D.  
 (Address) Centerville, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

50M-9-19-38 I X16025

1243

(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. 4-132

P. O. Address Columbia, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. (40)

Primary Registration District No. 15122

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Hallsville, Mo.  
(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 Benjamin P. Austene

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 \_\_\_\_\_ years

7. Birth date of deceased March 17 1865  
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 17 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation Carpenter

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Dr. Benj Austenes

13. Birthplace Mass.  
(City, town, or county) (State or foreign country)

14. Maiden name Susan Stubblefield  
(City, town, or county) (State or foreign country)

15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Quiby West  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 24 year 1941 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 \_\_\_\_\_  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(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?  
\_\_\_\_\_ (Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

PERMANENT

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-5512 - 1945