

FILED JUN 2 1945

Registration District No. 80

Primary Registration District No. 3017

Registrar's No. 54

1. PLACE OF DEATH:

(a) County **COOPER**
(b) City or town **BOONVILLE** Mo-
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **ST. JOSEPH'S HOSPITAL** 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **11 days** ← years (Specify whether years, months or days)

3. (a) PRINT FULL NAME **AUSTIN JAMES CHOATE CHOATE**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **NONE** 6. (c) Age of husband or wife if alive **1554 1884** years

7. Birth date of deceased **MARCH 11** (Month) (Day) (Year)

8. AGE: Years **61** Months **1** Days **24** If less than one day hr. min.

9. Birthplace **SALINE COUNTY MISSOURI** (City, town, or county) (State or foreign country)

10. Usual occupation **FARMER**

11. Industry or business **FARMING**

12. Name **JAMES CHOATE**

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

14. Maiden name **LUCINDA JACKSON**

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

16. (a) Informant **MRS MARGERET POINDEXTER**

(b) Address **BOONVILLE, MO**

17. (a) **BURIAL** (b) Date thereof **5/8/45** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **NELSON, MISSOURI**

18. (a) Signature of funeral director **STEGNER & KOENIG**

(b) Address **BOONVILLE, Mo.**

19. (a) **May-5-45** (b) **Dr. Chas. Swap** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **COOPER** 27
(c) City or town **BOONVILLE** 1
(If outside city or town limits, write "RURAL") 2
(d) Street No. **FOURTH STREET** (If rural, give location)
(e) Citizen of foreign country? **NO** 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **5** year **1945** hour **8** minute **- 7** M.

21. I hereby certify that I attended the deceased from **April 15 1945** to **May 5 1945** and that death occurred on the date and hour stated above. **May 4 1945**

Immediate cause of death **Coronary occlusion** Duration **1 hr.**
Due to **Arterio Sclerosis (General)** yrs.

Due to _____
Other conditions **Syphilitic - Enlarged Prostate** (Include pregnancy within 6 months of death)

Major findings: Of operations **no operations** Of autopsy **30g** 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) (c) Means of injury _____
23. Signature **M.H. Ziegler** (M. D. or other) **M.D.** Address **Boonville Mo.** Date signed **5-5-45**

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

27
1
2

RECEIVED

District Health Officer No: 8,

District File Number

Date Filed

6/14/4

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

James W. Stegner

Licensed Embalmer No. *3780*

P. O. Address *Boonville, W*

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.