No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27847

FILED AUG 18 1945

Registration District No. 2 Primary Registration District No. 57-3-64314 Registrar's No.

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Atlanta
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community Most all His Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon
(c) City or town Atlanta Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Eagle Township
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Thomas C. Auspach
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Nellie Auspach
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec (Month) 21 (Day) 1870 (Year)

8. AGE: Years 74 Months 7 Days 8 If less than one day hr. min.

9. Birthplace Dayton (City, town, or county) Ohio (State or foreign country)
10. Usual occupation Retired
11. Industry or business Farming
12. Name of father Peter Auspach
13. Birthplace of father Dayton (City, town, or county) Ohio (State or foreign country)
14. Maiden name of mother Catherine McClain
15. Birthplace of mother Near Dayton (City, town, or county) Ohio (State or foreign country)
16. (a) Informant Mrs Nellie Auspach
(b) Address Atlanta Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Cash Cemetery
18. (a) Signature of funeral director Tom Harding
(b) Address Atlanta Mo
19. (a) July 31 1945 (Date received by local registrar) (b) Mrs. G. L. Combs (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29
year 1945 hour 9 minute 15 A.M.
21. I hereby certify that I attended the deceased from July 28, 1945, to July 29, 1945
that I last saw him alive on 7-29, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to: Hypertension	
Due to:	
Other conditions: Arteriosclerosis (Include pregnancy within 3 months of death)	
Major findings: Of operations:	
Of autopsy: None	

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature G. L. Combs (M. D.)
Address Atlanta Mo Date signed 8-1-45

1054

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 8-45-1231
Date Filed AUG 16 1945

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 H M Goodwin

Licensed Embalmer No. 175-0

P. O. Address Atlanta, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.