No. 2
-3-43
6-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 28 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3666

State File No.

Registration District No. 218 Primary Registration District No. 4413 Registrar's No.

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Frankford (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 -
In this community 65 years - (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pike 82
(c) City or town Frankford 0 (If outside city or town limits, write "RURAL")
(d) Street No. J (If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME CARLTON S. 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 9
6. (b) Name of husband or wife MARTHA JANE AUSTIN
6. (c) Age of husband or wife if alive years
7. Birth date of deceased NOV (Month) 19 (Day) 1859 (Year)

8. AGE: Years 86 Months 1 Days If less than one day hr. min.

9. Birthplace Saginaw (City, town, or county) Michigan (State or foreign country)
10. Usual occupation Retired Farmer
11. Industry or business

FATHER
12. Name Jeremiah Austin
13. Birthplace Michigan (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Frances Sage
15. Birthplace Michigan (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. John Dutle
(b) Address Frankford, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21 45 (Month) (Day) (Year)
(c) Place: burial or cremation Bethel, Mo.
18. (a) Signature of funeral director Fuesor & Son
(b) Address Frankford Mo.
19. (a) 12/21/45 (Date received local registrar) (b) Margaret E. Stephens (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19 year 1945 hour 1:15 AM. minute M.
21. I hereby certify that I attended the deceased from April 6 1945, to Dec. 19 1945, that I last saw him alive on Dec. 18 1945, and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Uremic Poisoning
due to Pneumonia
Due to Heart Failure & Paralysis
Due to Paralysis of 5 yrs. duration

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTAL INFORMATION REQUESTED

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

23. Signature E. P. Hansen (M. D. or other) DO.
Address Frankford, Mo. Date signed 12/26/45

265 (Licensed Embalmer's Statement on Reverse Side)

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

10727

RECEIVED
District Health Office No. 10
Registered File Number 1-46-187
Date Filed JAN 26 1946

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 Dow Fields Megown

Licensed Embalmer No. 4093

P. O. Address Frankfort, Ky.

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.

No. 2B
I—3-45
P I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3666

Registration District No. 278 Primary Registration District No. 443 Registrar's No.

1. PLACE OF DEATH:

(a) County Pike

(b) City or town Frankford
(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 Carlton S. 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 Married

6. (b) Name of husband or wife Florida Jane Austin

6. (c) Age of husband or wife if alive ? years

7. Birth date of deceased Nov. 19
(Month) (Day) (Year)

8. AGE: Years 86 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 19
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 ; to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremic Poison	
Due to Lobar Pneumonia	
Due to Heart failure	
Due to paralysis of 5 yrs duration	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 10/

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:

(c) 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 12/21/45

SUPPLEMENTARY

100727 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD