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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 25 1946

State File No. 30048

Registration District No. 128 Primary Registration District No. 5466 Registrar's No. 739

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Rural, S. Campbell Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Ozark Osteopathic Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk

(c) City or town Halfway
(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 Lawrence Austin

3. (b) If veteran, name war UNK.

3. (c) Social Security No. UNK.

4. Sex MALE

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None

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

7. Birth date of deceased Nov. 27. 1919 (Month) (Day) (Year)

8. AGE: Years 26 Months 9 Days 11 If less than one day hr. min.

9. Birthplace Polk Co. Mo U (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Alvas Austin
13. Birthplace Halfway Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Martha Moore
15. Birthplace Polk Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Lillian Moore

(b) Address Oakland Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 8-1946 (Month) (Day) (Year)

(c) Place: burial or cremation Polk Co.

18. (a) Signature of funeral director [illegible]

(b) Address Springfield Mo.

19. (a) 9-9-46 (Date received local registrar) (b) W. Hardy MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 8 year 1946 hour 3 minute 30 p. M.

21. I hereby certify that I attended the deceased from 8-26 1946 to 9-8 1946, that I last saw him alive on 9-8 1946, and that death occurred on the date and hour stated above.

Immediate cause of death General Peritonitis

Due to Gangrenous Appendix

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 R. A. Michael (M.D., or other)

Address Springfield Mo. Date signed 9-9-46

(Licensed Embalmer's Statement on Reverse Side)

OCT 4 1946

DEC 5 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.....

Licensed Embalmer No.....

P. O. Address.....

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.