

No. 2
1-2-43
5-17-39
X39697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40192

FILED JAN 9 1947
Registration District No. 128

Primary Registration District No. 2000

State File No. _____

Registrar's No. 1026

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 da.
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dallas 30

(c) City or town Elkland Rural 1
(If outside city or town limits, write "RURAL")

(d) Street No. Rural 1
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME William Riley Austin

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race wht 6. (a) Single, widowed, married, divorced married

7. Birth date of deceased: July 10 1879
(Month) (Day) (Year)

6. (b) Name of husband or wife LAVANA 6. (c) Age of husband or wife if alive 71 years
(Day) (Year)

8. AGE: Years 73 Months 5 Days 9 If less than one day hr. _____ min. _____

9. Birthplace Elkland, Dallas Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Daniel Austin 9

13. Birthplace unknown 1
(City, town, or county) (State or foreign country)

14. Maiden name Ann Clark 11

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

16. (a) Informant Mrs. Maggie Newman

(b) Address 1704 N. Atlantic Springfield Mo

17. (a) Burial (b) Date thereof Dec 22 - 4
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Mount Dallas Co Mo

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

(b) Address 113 Jones

19. (a) 12-26-46 (b) W. E. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19 year 1946 hour 9 minute 40 a.m.

21. I hereby certify that I attended the deceased from Dec. 3 1946 to Dec 19 1946
that I last saw him alive on Dec 19 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration acute

Due to Generalized arterio-sclerosis many years

Due to Diabetes mellitus 3-4 years

Other conditions (includes pregnancy within 3 months of death) 61

Major findings: left ty gangrenous and vessels arteriosclerosis

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:

(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? Y

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

23. Signature [Signature] (M. D. or other) MD

Address 500 Holland Bldg - Springfield Date signed 12-26-46

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

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

Leonard Blom

Licensed Embalmer No.....

2108

P. O. Address.....

Buffalo

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.