

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1667

BIRTH NO. _____ REG. DIST. NO. 165 PRIMARY REG. DIST. NO. 5611 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY Johnson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Johnson	
b. CITY (If outside corporate limits, write RURAL and give town(ship)) Rural Chilhowee	c. LENGTH OF STAY (In this place) 39yrs	c. CITY (If outside corporate limits, write RURAL and give town(ship)) Rural Chilhowee	
d. FULL NAME OF HOSPITAL OR INSTITUTION Rural Chilhowee		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) James	b. (Middle) Alfred	c. (Last) Austin	4. DATE OF DEATH (Month) (Day) (Year) Jan. 15, 1949		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 3, 1872	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months 4	IF UNDER 1 YEAR Days 12	IF UNDER 1 YRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Cowden, Ill.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Samuel Austin	13b. MOTHER'S MAIDEN NAME Lucretia Dildine	14. NAME OF HUSBAND OR WIFE Zella Mae Austin
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. X	17. INFORMANT'S SIGNATURE OR NAME Mrs. J. Edgar Davis, Chilhowee, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal uremia	DUE TO (b) Renal Cardiovascular disease		
DUE TO (c) Generalized arteriosclerosis	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Renal 442X		

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE none	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Aug 4, 1944, to Jan 15, 1949, that I last saw the deceased alive on Jan 13, 1949, and that death occurred at 9 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. D.	23b. ADDRESS Warrensburg, Missouri	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/17/49	24c. NAME OF CEMETERY OR CREMATORY Sunset Hill	24d. LOCATION (City, town, or county) (State) Warrensburg, Mo.
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DATE REC'D BY LOCAL REG. Jan 18-49	REGISTRAR'S SIGNATURE M. Marie Blackwell	25. FUNERAL DIRECTOR'S SIGNATURE J.W. Cook, Chilhowee, Missouri.	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

J. W. Cook

Signed _____
Student Embalmer

Licensed Embalmer No. *4335*

P. O. Address *Chilhowee, N.C.*

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.