

FILED APR 11 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7682

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <u>61</u>		PRIMARY REG. DIST. NO. <u>4107</u>		Registrar's No. <u>30</u>	
1. PLACE OF DEATH a. COUNTY <u>Cedar</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence) before a. STATE <u>Missouri</u> b. COUNTY <u>Cedar</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>El Dorado Spgs.</u>		c. LENGTH OF STAY (In this place) <u>2 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>El Dorado Springs</u>		0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>				d. STREET ADDRESS (If rural, give location) <u>309 Westland</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>JAMES</u>		b. (Middle) <u>M.</u>		c. (Last) <u>AUSTIN</u>	
4. DATE OF DEATH		(Month) (Day) (Year)		<u>MAR. 24, 1949</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Aug. 13, 1860</u>	
9. AGE (In years last birthday) <u>88</u>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Charles C. Austin</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Cline</u>		14. NAME OF HUSBAND OR WIFE <u>Roxie Anna Austin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Roxie Anna Austin</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral apoplexy,</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Cerebral apoplexy, cerebral paralysis</u> DUE TO (c) <u>24</u> 2. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
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?			
22. I hereby certify that I attended the deceased from <u>3-24</u> , 19 <u>49</u> , to <u>3-24</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>3-24</u> , 19 <u>49</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>John Hill</u>		(Degree or title) <u>M.D.</u>		23b. ADDRESS <u>El Dorado Springs</u>		23c. DATE SIGNED <u>26 Mar 49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3-26-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>El Dorado Springs</u>		24d. LOCATION (City, town, or county) (State) <u>El Dorado Springs</u>	
DATE REC'D BY LOCAL REG. <u>MARCH 28, 1949</u>		REGISTRAR'S SIGNATURE <u>per El Dorado Springs</u>		FUNDAMENTAL DIRECTOR'S SIGNATURE (ADDRESS) <u>per El Dorado Springs</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED  
District Health Officer No. 7,  
District File Number 3-42-32-5  
Date Filed 4-15-89

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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.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4419

P. O. Address Donald Sapp

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.