

FILED MAY 4 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11614

BIRTH NO. _____		REG. DIST. NO. 99		PRIMARY REG. DIST. NO. 5377		Registrar's No. 28		
1. PLACE OF DEATH a. COUNTY DeKalb				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY DeKalb				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fairport				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fairport				
d. FULL NAME OF HOSPITAL OR INSTITUTION Home				d. STREET ADDRESS (If rural, give location)				
3. NAME OF DECEASED (Type or Print) Phillip Pious			a. (First) b. (Middle) c. (Last) Augustus			4. DATE OF DEATH (Month) (Day) (Year) 4 15 54		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 11-19-1887		
9. AGE (In years last birthday) 68		10. KIND OF BUSINESS OR INDUSTRY Sawmill operator		11. BIRTHPLACE (City and State or Foreign Country) Mo		12. CITIZEN OF WHAT COUNTRY? U.S.		
13a. FATHER'S NAME George Augustus			13b. MOTHER'S MAIDEN NAME Susie Down			14. NAME OF HUSBAND OR WIFE Myrtle Augustus		
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. XXXXXX			17. INFORMANT'S SIGNATURE OR NAME Myrtle Augustus		
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
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) 331 X		
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 May 1954 to 4/15, 1954, that I last saw the deceased alive on 4/14, 1954, and that death occurred at 8:35 Am., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) W. Harold Fowler, M.D.			23b. ADDRESS Mayaville Mo			23c. DATE SIGNED 4/15/54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial			24b. DATE 4-18-54			24c. NAME OF CEMETERY OR CREMATORY Berlin Mo.		
24d. LOCATION (City, town, or county) (State) Mayaville Mo			25. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS		
DATE REC'D BY LOCAL REG. 4-20-54			REGISTRAR'S SIGNATURE Jacob H. Nardine			26. ADDRESS		

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 3933

P. O. Address Mayeville MO

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.