

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

17576

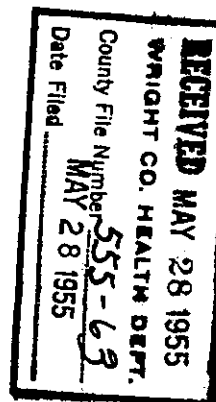
State File No.

FILED MAY 31 1955

BIRTH NO.		REG. DIST. NO. <u>375</u>		PRIMARY REG. DIST. NO. <u>6284</u>		Registrar's No. <u>13</u>	
1. PLACE OF DEATH a. COUNTY <u>WRIGHT</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>WRIGHT</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL MONTGOMERY</u>		c. LENGTH OF STAY (In this place) <u>LIFE</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL MONTGOMERY</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) <u>3 MILES NORTH MANES, MO</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>EARL</u>		b. (Middle) <u>ERNEST</u>		c. (Last) <u>AUSTIN</u>	
4. DATE OF DEATH		(Month) <u>MAY</u>		(Day) <u>19</u>		(Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>OCT 22 1898</u>		9. AGE (In years last birthday) <u>56</u>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY STORE</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ASTORIA MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JAMES ALLEN AUSTIN</u>		13b. MOTHER'S MAIDEN NAME <u>MARTHA FLOYD</u>		14. NAME OF HUSBAND OR WIFE <u>MYRTLE DUFF</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 ADDRESS <u>Myrtle Austin Manes, Mo.</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Embolism</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary Heart Disease</u> 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 <u>Sudden</u> <u>2 weeks</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION: <u>4201</u>				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>5-4</u> , 1955, to <u>5-18</u> , 1955, that I last saw the deceased alive on <u>5-18</u> , 1955, and that death occurred at <u>10:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>W. A. Craig, M.D.</u>		23b. ADDRESS <u>Mountain Grove Mo.</u>		23c. DATE SIGNED <u>5-23-55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>MAY 24 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNTAIN</u>		24d. LOCATION (City, town, or county) (State) <u>GREEN MOUNTAIN MO.</u>	
DATE REC'D BY LOCAL REG. <u>5-26-55</u>		REGISTER'S SIGNATURE <u>E. J. Farmer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Barbe</u>		ADDRESS <u>Manes, Mo.</u>	

(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. _____

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.