

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011961
STATE FILE NUMBER

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| FILED APR 9 1959 | | Registration District No. 333 | | Primary Registration District No. 2074 | | Registrar's No. 58 | |
| 1. PLACE OF DEATH a. COUNTY Scott | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Scott | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR Sikeston TOWN | | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Benton 1000 | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Delta Comm. Hosp. | | | | Length of stay in lb 9 Hrs. | | d. STREET ADDRESS (If outside, give location) Route #1 | |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle ASBURY Last AUSTIN | | | | 4. DATE OF DEATH Month 3 Day 30 Year 1959 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-3-1887 | |
| 9. AGE (In years last birthday) 71 | | IF UNDER 1 YEAR Months 7 Days 27 | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during usual working life, even if retired) Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (City and state or country) Senath, Missouri | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13a. FATHER'S NAME Francis Austin | | | | 13b. MOTHER'S MAIDEN NAME Elvina Reed | | 14. NAME OF HUSBAND OR WIFE Ella Austin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown) (If yes, give dates of service) NO | | | | 16. SOCIAL SECURITY NO. 500-4264485 | | 17. INFORMANT Address Mrs. Ella Austin Rt. # 1 Benton, Mo. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral occlusion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Sen. arteriosclerosis DUE TO (c) 4201 | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 hrs 7 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | | |
| 21. I attended the deceased from 3/30/59 to 3/30/59 and last saw her alive on 3/30/59 Death occurred at 5:15 P. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE Wm. C. Cuthbertson M.D. (Degree or title) | | | | 22b. ADDRESS Sikeston, Mo. | | 22c. DATE SIGNED March 31, 1959 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 4-2-59 | | 23c. NAME OF CEMETERY OR CREMATORY McGrew Cemetery | | 23d. LOCATION (City, town, or county) (State) Senath, Missouri | |
| 24. FUNERAL DIRECTOR Nunnelee Funeral Chapel Sikeston, Mo. | | | | 25. DATE RECD. BY LOCAL REG. 4-2-59 | | 26. REGISTRAR'S SIGNATURE Mrs. Ella Austin | |

(Licensed Embelmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Director, coroner, etc., must use only standard nomenclature in Part 1b. No symptoms will be listed. All diseases in Part I must be causally related.

APR 16 1959

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
Signature of Student Embalmer

Signed Philip J. Casady
Licensed Embalmer No. 4618
P. O. Address Likertown, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.