

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035432

FILED VS OCT 27 1959 53

3010

374

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <i>Cape Girardeau</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Pollinger</i>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Cape Girardeau</i>		Length of stay in lb <i>4 days</i>		c. CITY OR TOWN <i>near Sedgewickville</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>S.E. Mo Hospital</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <i>near Sedgewickville</i>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <i>CAD</i> Middle <i>J.</i> Last <i>AUSTIN</i>				4. DATE OF DEATH Month <i>SEPT</i> Day <i>30</i> Year <i>1959</i>											
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb 4, 1904</i>		9. AGE (last birthday) <i>55</i>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Stock Raising</i>		11. BIRTHPLACE (City and state or country) <i>Millersville Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>							
13a. FATHER'S NAME <i>Lee Austin</i>				13b. MOTHER'S MAIDEN NAME <i>Vesta Crites</i>				13c. NAME OF HUSBAND OR WIFE <i>Pearl Baker Austin</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give year or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>No</i>				17. INFORMANT Address <i>Ord Austin Jackson Mo</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <i>Cerebral metastases</i>															
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Carcinoma, lung, bronchogenic</i>										<i>undefinite</i>					
DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m.		Month, Day, Year													
20d. INJURY OCCURRED WHILE AT WORK <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 <i>9-16-59</i> , to <i>9-30-59</i> and last saw him alive on <i>9-29-59</i> Death occurred at <i>4:25AM</i> m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <i>Dr. R. Cochran MD</i> (Degree or title)								22b. ADDRESS <i>Cape Girardeau, Mo.</i>				22c. DATE SIGNED <i>10-19-59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Oct 27 1959</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Embanah</i>				23d. LOCATION (City, town or county) (State) <i>near Millersville Mo.</i>							
24. FUNERAL DIRECTOR <i>J. Miller Jackson Mo.</i> ADDRESS				25. DATE RECD. BY LOCAL REG. <i>10-20-59</i>				26. REGISTRAR'S SIGNATURE <i>Jane Kasten</i>							

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

YS NOV 25 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

Gene C. Crang

Licensed Embalmer No.

432

P. O. Address

Joe Smith

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.