

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-016070

FILED VS MAY 2 1960

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3440 Registrar's No. 86

1. PLACE OF DEATH a. COUNTY <b>Livingston</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Carroll</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Chillicothe</b>		Length of stay in 1b <b>1 day</b>		c. CITY OR TOWN <b>Norborne R.F.D. # 1</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chillicothe Memorial</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>R.F.D. # 1</b>		Reside on Prem Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Homer</b> Middle <b>P.</b> Last <b>Austin</b>				4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-25-1890 60</b>		9. AGE (last Birthday) IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (City and state or country) <b>Placer County, Calif., U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY		
13a. FATHER'S NAME <b>George Austin</b>			13b. MOTHER'S MAIDEN NAME <b>Etta Simpson</b>			13c. NAME OF HUSBAND OR WIFE <b>Glenn Standley Austin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>493-12-4548</b>		17. INFORMANT Address <b>Mrs. H.P. Austin Norborne, Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chr. Myocarditis</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Bronchiogenic Carcinoma right.</b>						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 type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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 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 <b>Apr 10, 1960</b> to <b>Apr 24, 1960</b> and last saw <sup>her</sup> him alive on <b>Apr 24, 1960</b> Death occurred at <b>4:45 p.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>H. M. Dowell, M.D.</b> (Degree or title)				22b. ADDRESS <b>Chillicothe Mo</b>				22c. DATE SIGNED <b>4-27-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-27-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City, town, or county) <b>Carrollton, Missouri</b>		(State)	
24. FUNERAL DIRECTOR <b>GIBSON FUNERAL HOME CARROLLTON, MO.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>4/27/60</b>		26. REGISTRAR'S SIGNATURE <b>Francis B Kell</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James F. Gibson

Licensed Embalmer No. 5076

P. O. Address Carrollton, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

PROCESSED: 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.