

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-028867

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 151

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 9 1963		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Jasper</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u> admission	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Carthage</u> Length of stay in 1b <u>31 da.</u>		c. CITY OR TOWN <u>Avilla</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>McCone Brooks</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>Austin</u>			4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-1-1879</u>
9. AGE (last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>9</u> Days <u>27</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer & Stockman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Jasper Ch. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Aaron Austin</u>		13b. MOTHER'S MAIDEN NAME <u>Teresia Bottom</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</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>[Redacted]</u>	17. INFORMANT <u>Herbert Austin</u> Address <u>Avilla Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u>			<u>2 years</u>
DUE TO (b) <u>Generalized arteriosclerosis</u>			<u>?</u>
DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture right femur.</u>			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.) <u>Fell on floor in own home.</u>	
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u>6/24/63</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>Avilla</u>	COUNTY <u>Jasper</u>	STATE <u>Missouri</u>
21. I attended the deceased from <u>6/26/63</u> to <u>7/28/63</u> and last saw him ^{XXXX} alive on <u>7/28/63</u> . Death occurred at <u>9</u> <u>0</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Charles L. Seibel, M.D.</u>		22b. ADDRESS <u>Medical Building, Carthage, Mo.</u>	22c. DATE SIGNED <u>7/30/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal & Burial</u>	23b. DATE <u>7-31-1963</u>	23c. NAME OF CEMETERY OR CRYPTORY <u>Summit</u>	23d. LOCATION (City, town, or county) (State) <u>N.E. of Miller Mo.</u>
24. FUNERAL DIRECTOR <u>Maximo Seiman</u> ADDRESS <u>Miller Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-31-63</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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

E. D. Seiman

Licensed Embalmer No. 3297

P. O. Address Miller 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.