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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11268

FILED JAN 12 1945

State File No.

Registration District No. 137

Primary Registration District No. 3023

Registrar's No. 228

1. PLACE OF DEATH:

(a) County Clinton Henry

(b) City or town Clinton MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks
(Specify whether years, months or days)

In this community 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MO

(b) County Henry 42

(c) City or town Clinton - Rural 0
(If outside city or town limits, write "RURAL.")

(d) Street No. Rural
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME NOBLE AUSTIN

3. (b) If veteran, name war WWI

3. (c) Social Security No. 0

4. Sex M 0

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ethel

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased 11-23 (Month) 1877 (Day) 1877 (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>67</u>	<u>1</u>	<u>4</u>	hr. min.

9. Birthplace Charlottesville Va
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name ~~Wm Austin~~ Wm Austin

13. Birthplace Va
(City, town, or county) (State or foreign country)

14. Maiden name Christine Wood

15. Birthplace Va
(City, town, or county) (State or foreign country)

16. (a) Informant Ethel Austin

(b) Address Clinton MO

17. (a) 0 (b) Date thereof: 12-29-1944
(Burial, or removal, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethelam Cem

18. (a) Signature of funeral director E. C. Peeler

(b) Address Clinton MO

19. December 29 1944 (Date received local registrar)
Georgia Kitcher (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 27
year 1944 hour 8:30 minute PM

21. I hereby certify that I attended the deceased from 11-23 1944 to 12-27 1944
that I last saw him alive on 11-27 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Uræmia

Due to Chronic Valvular Endocarditis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place) (Specify means of injury)

23. Signature E. C. Peeler (Registrar's signature)
Address Clinton MO Date signed 12/29/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER, FATHER

1669

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 7,

District File Number 12-44-1487

Date Filed 1-11-45

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Fred W. Reese

Licensed Embalmer No. 2478

P. O. Address Clinton, 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 this body is not embalmed, fact should be so stated above.

Registration District No. 137

Primary Registration District No. 3028

Registrar's No. 228

1. PLACE OF DEATH:

(a) County Henry Clinton
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Robt Austin

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 23 1878
(Month) (Day) (Year)

8. AGE: Years 67 Months 1 Days 23 If less than one day, hr. 23 min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 7
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____

that I last saw him _____ alive on _____ 19____ and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to Phonico Valvular Endocarditis and Myocardial fracture

Other conditions: (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature W. C. Peeler (M. D. or other) _____
Address Union Mo Date signed 1-16-45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

41268