

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

28433

214

1. PLACE OF DEATH

County West Madrid Registration District No. 609
 Township Libbourn Primary Registration District No. 5702
 City Libbourn No. 1011 St. Ward

File No. 94

Registered No.

2. FULL NAME

(a) Residence. No. St. Ward.
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Audora Austin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 6, 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ___ hrs. or ___ min.
68 9 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mgr Barber Shop
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Des Moines
 (STATE OR COUNTRY) Iowa

10. NAME OF FATHER Charley Austin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Springfield Ill
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Martha Henning

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Janesville Ky
 (STATE OR COUNTRY)

14. INFORMANT Charley Austin
 (Address) Libbourn Ill

15. FILED 9/28/29 W. Bannan
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-26 1929

17. I HEREBY CERTIFY, That I attended deceased from , 1929, to , 1929, that I last saw h. alive on 9-27, 1929, and that death occurred, on the date stated above, at 9:27 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart Dropsy
Secondary
at the
9013

CONTRIBUTORY (SECONDARY)
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) M.D.
 , 19 29 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE, CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mounds Cem DATE OF BURIAL 9-26 1929

20. UNDERTAKER ADDRESS

REC-26 1929

N. B. - CAUSE



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County N. Madrid Registration District No. 274 File No. _____
 Township _____ Primary Registration District No. 4063 Registered No. _____
 City Tilbourn (No. _____) St. _____ Ward _____

2. FULL NAME

Charles M. Austin
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Audora Austin</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Oct 6-1861</u>		
7. AGE <u>67</u> yrs.	MONTHS <u>10</u>	DAYS <u>20</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Mgr. Barber Shop</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 26 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 9 21 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Heart Disease
died without medical attention

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) W. O. Bamann, M. D.
 , 19____ (Address) Health Office

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Des Moines Iowa

10. NAME OF FATHER Charley Austin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
Springfield Ill

12. MAIDEN NAME OF MOTHER Mablea Hennis

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)
Jameville Ky.

14. INFORMANT Charley Austin
 (Address) Tilbourn Ill.

15. FILED Oct 9 1929 E. E. Jones REGISTRAR

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mounds Cem. DATE OF BURIAL 8 26 1929

20. UNDERTAKER J. M. Hill ADDRESS Tilbourn Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD
 N. B. -Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms. That it may be properly classified. Exact statement of OCCUPATION in very plain language.
 REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL HED, AND COMPLETE AS PRESCRIBED BY LAW

PRELIMINARY

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