

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

Do not use this space.

28704

**1. PLACE OF DEATH**

County St. Clair  
Township Center  
City Louisy City (No. ....) St. .... Ward)

Registration District No. 763  
Primary Registration District No. 4458

File No. ....  
Registered No. 174

**2. FULL NAME**

William Franklin 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 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 Sarah A. Austin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 11 1855

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .... hrs. or .... min.
	<u>74</u>	<u>4</u>	<u>23</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Virginia

10. NAME OF FATHER John Austin

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

12. MAIDEN NAME OF MOTHER Louise Broyles

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

14. INFORMANT W. C. Austin (Address) Louisy City, Mo.

15. FILED 9/20 1929 Lo S Wright REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 4, 1929

17. I HEREBY CERTIFY, That I attended deceased from July 30, 1929, to Aug 4, 1929, that I last saw him alive on Aug 4, 1929, and that death occurred, on the date stated above, at 7:30 P.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Paralysis  
82 A  
82 D (duration) yrs. mos. 20 ds.

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

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF.....

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS..... (Signed) E. S. Stalter, M. D. Aug 5, 1929 (Address) Louisy City, Mo

\*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 DATE OF BURIAL Englewood Cemetery Aug. 5, 1929

20. UNDERTAKER ADDRESS Austin Bros. Co. Louisy City, Mo.

23 SEP 26 1929  
 3  
 3  
 N. B. If supplied, AGE should be that may be properly classified. CAUSE  
 235

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Clair Registration District No. 763 File No. \_\_\_\_\_  
 Township Lourey City Primary Registration District No. 4458 Registered No. 14  
 City Lourey City (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

William Franklin 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 ( <i>write the word</i> ) <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE	YEARS	MONTHS
		DAYS
		If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
PARENTS	10. NAME OF FATHER	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>	
	12. MAIDEN NAME OF MOTHER	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>	
14. INFORMANT (Address)		
15. FILED <u>8/20/29</u> <u>Leo S Wright</u> REGISTRAR		

**MEDICAL CERTIFICATE OF DEATH**

15. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 4 1929

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Paralysis from cerebral hemorrhage  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

18. WHERE WAS DISEASE CONTRACTED? 7401  
 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\_\_\_\_ (Address)

\*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	DATE OF BURIAL _____ 19____
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY  
 THIS IS A PERMANENT RECORD

Every item of information should be carefully checked. AGE should be stated in exact terms, and sex should be stated. Exact date of death should be stated. Exact date of occupation is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact date of occupation is very important. REGISTER A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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