JUL 25 1935

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

Do not use this space.

20573

1. PLACE OF DEATH
County: Osage Co
Township: Bright Star
City: (No. ..., ... St. ..... Ward)

Registration District No. 639
Primary Registration District No. 4383

File No.
Registered No.

2. FULL NAME: Harold Dixie Austin

(a) Residence, No. (St Aubert 80) 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: Mgro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Infant

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: —

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

7. AGE: Years 0 | Months 0 | Days 8 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Infant
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: —
10. Date deceased last worked at this occupation (month and year): —
11. Total time (years) spent in this occupation: —

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): St Aubert Mo

FATHER
13. NAME: James R Austin
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Oklahoma

MOTHER
15. MAIDEN NAME: Bertie Elley
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Chamois Mo

17. INFORMANT (ADDRESS): James R Austin St Aubert Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE: St Aubert DATE: 6 - 25 - 1935

19. UNDERTAKER (ADDRESS): James Austin St Aubert Mo

20. FILED: June 27 1935 Esther Souder Registrar
Alberta Souder

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 6 - 25, 1935

22. I HEREBY CERTIFY, That I attended deceased from 6-18 1935, to 6-25 1935
I last saw him alive on 6-18, 1935. Death is said to have occurred on the date stated above, at 3 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Convulsions of Unknown Cause. Probably acute meningitis (Certain)	6-25
Did not see baby after birth which seemed normal & healthy at birth	"

Other contributory causes of importance:

Name of operation: None Date of
What test confirmed diagnosis? Report from father Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) W H Williamson, M. D.
(Address) Mokane Mo

Rep.

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

ALL INFO Do not use this space. FOR MUST BE WRITTEN THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Osage — Registration District No. 639 — File No.
Township — Primary Registration District No. 4383 — Registered No.
City (No. , St. Ward)

2. FULL NAME Harold Dine Austin
(a) Residence, No. St., Ward. (If nonresident, give city or town and State)
(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.

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: C
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-17-1935

7. AGE — YEARS — MONTHS — DAYS 8 — If LESS than 1 day, ... hrs. or ... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 6-27 1935 Esther Souder
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-25-1935

22. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
I last saw h alive on , 19 Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:

Convulsions of unknown cause probably acute meningitis

Was not epidemic in form

Date of onset

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury , 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) W. H. Williamson, M. D.
(Address) Mokane Mo

AUG 6 1935

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