

DEC'D MAR 9 1939

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

7827
Do not use this space.

1. PLACE OF DEATH
 (a) County Dr. Lewis Registration District No. 784
 (b) Township _____ Primary Registration District No. 111 Registered No. 381
 (c) City Rock Hill (d) Street No. St. Marys Hospital St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 235 Charles H. Austin
 2. PRINT FULL NAME
 (a) Residence, No. 445.87 Dr. Lewis St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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 Emily Thomas
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 12 - 1878
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
60 2 19
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Oil burner
 9. Industry or business in which work was done, as 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) Mo.
 13. NAME J. W. Austin
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.
 15. MAIDEN NAME Rachel Pepper
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MAR 1 - 1939 19
 22. I HEREBY CERTIFY, That I attended deceased from 2 - 22, 1939, to 3 - 1, 1939
 I last saw him alive on 3 - 1, 1939. Death is said to have occurred on the date stated above, at 4:00 p. m.
 The principal cause of death and related causes of importance were as follows:
Coronary Occlusion
 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) Daniel V. Nelson, M. D.
 (Address) 607 North Grand Ave

17. INFORMANT James F. Austin
 (ADDRESS) 5238 Bontune
 18. BURIAL, CREMATION, OR REMOVAL
 PLACE Pal. Cem. DATE Mar 4, 1939
 19. FUNERAL DIRECTOR Walter Washington
 (ADDRESS) 4465 Washington
 20. FILED MAR 2 1939 J. R. Meyer Local Registrar.

2 1939
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

#116 - 323
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STATEMENT BY LICENSED EMBALMER

I, Thomander Gray, Licensed Embalmer No. 826

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. _____ or by _____
working under my personal supervision.

Signed Thomander Gray, Registered Apprentice No. _____
Licensed Embalmer No. 826

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.)

Sept 1900