

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

9389
 Do not use this space.

REC'D APR 17 1939

1. PLACE OF DEATH *Jackson 2*

(a) County *Jackson* Registration District No. *399*

(b) Township *Itaw* Primary Registration District No. *1002*

(c) City *Ita Mo* (d) Street No. *3125 E. 9 St* Registered No. *995*

(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.

2. PRINT FULL NAME *Sarah Austin*

(a) Residence, No. *3125 E. 9 St* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widow*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Nov. 14, 1854*

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>84</i>	<i>3</i>	<i>20</i>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *housewife*

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*

FATHER

13. NAME *Jas Carter*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

MOTHER

15. MAIDEN NAME *Sarah Carter*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

17. INFORMANT *Mrs Homer Howard* (ADDRESS) *8125 E 9th St*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Belot from Mo* DATE *3/5/39*

19. FUNERAL DIRECTOR (NAME) *H. F. Mayberry* (ADDRESS) *2315 Linwood Blvd*

20. FILED *Nov 6, 1939* M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *3-4-39*

22. I HEREBY CERTIFY, That I attended deceased from *2-28-39*, 19... to *3-4-39*, 19... I last saw him alive on *3-4-39*, 19... Death is said to have occurred on the date stated above, at *11:30* m.

The principal cause of death and related causes of importance were as follows:
Chronic Myocarditis
with cardiac decompensation

Date of onset

Other contributory causes of importance:
Pneumonia

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? *no*

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) *P. H. De Moran*, M. D.
 (Address) *Superior Hospital*

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.

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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, above space should be left blank.