

Registration District No. 135

Primary Registration District No. 3010

Registrar's No. 125

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Scovena Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify number)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Carroll
(c) City or town Carrollton
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

In this community _____ years, months or days
8. (a) PRINT FULL NAME William F. Austin
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 24 year 1939 hour 11 minute 30 P. M.
21. I hereby certify that I attended the deceased from 10-24-39 to 10-24-39
that I last saw him alive on 10-24-39, 19____, and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

Immediate cause of death External injuries of
Gun - Protrusion and Wound
Due to Assault by Other
Children a Gun Injury
Due to _____
Other conditions (Include pregnancy within 3 months of death) 194

7. Birth date of deceased: Oct. 28 1936
(Month) (Day) (Year)
8. AGE: Years 2 Months 11 Days 26 If less than one day _____ hr _____ min.

Major findings: Penetration of Gun
Intestines and Stomach
Of autopsy _____

9. Birthplace: Carrollton, Mo
(City, town, or county) (State or foreign country)
10. Usual occupation _____
11. Industry or business _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident a assault
(b) Date of occurrence Oct 21-39
(c) Where did injury occur? Carrollton (City or town) Carroll (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? about home
(Specify type of place) (e) Means of injury _____
While at work _____
23. Signature H. G. Jones (M. D. or other) M.D.
Address Carrollton Mo Date signed 10-23-39

MOTHER FATHER
12. Name Clifford W. Austin
13. Birthplace Carrollton, Mo (City, town, or county) (State or foreign country)
14. Maiden name Carrollton, Mo
15. Birthplace Carrollton, Mo (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Clifford W. Austin
(b) Address Carrollton, Mo
17. (a) Burial (b) Date thereof 10/27-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Van Horn Cem.
18. (a) Signature of funeral director Ben W. Johnson
(b) Address Carrollton, Mo
19. (a) 10/27-39 (b) John Haskins
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
District Health Officer No. 8,
District File Number 117/39
Date Filed

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 Ben W Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton, Va

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.