

FILED AUG 19 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

28441
Do not use this space.

SEP 19 1940

1. PLACE OF DEATH

(a) County Dunklin Registration District No. 290

(b) Township Balsam Primary Registration District No. 5408

(c) City Rural (d) Street No. _____ St.

(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 Rulcie Farnum Austin (AULCIE)

(a) Residence, No. Rural (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 11-1932

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

17 8 4

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

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) May Squash (STATE OR COUNTRY) Dunklin Co. Mo.

13. NAME J. R. Austin

14. BIRTHPLACE (CITY OR TOWN) May Squash (STATE OR COUNTRY) Dunklin Co. Mo.

15. MAIDEN NAME May Stonum

16. BIRTHPLACE (CITY OR TOWN) Squash (STATE OR COUNTRY) Dunklin Co. Mo.

17. INFORMANT W. G. Long (ADDRESS) Squash Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Midway DATE 8-16-40

19. FUNERAL DIRECTOR (NAME) Dr. Daniel James (ADDRESS) Squash Mo.

20. FILED _____, 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 15 1940

22. I HEREBY CERTIFY, That I attended deceased from unattended for a physician
I last saw him alive on _____, 19 ____ Death is said to have occurred on the date stated above, at 8 a. m.
The principal cause of death and related causes of importance were as follows:
gun shot wound self inflicted
Date of onset 167

Other contributory causes of importance: _____

Verdict of Coroner James

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 Suicide Date of injury Aug. 15, 1940
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) George E. James M.D.
James (Address) Squash Mo.

K. 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. 2

District File Number 940 - 1430

Date Filed 9/7/40

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28441

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 290

Primary Registration District No. 3408

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Salem T. P.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months of _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dunklin

(c) City or town Rural Dunklin
(If outside city or town limits write "RURAL")

(d) Street No. near Beach Corner
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Aulcie Lorene Austin

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: month Aug day 15 year 1940 hour _____ minute _____ M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

8. AGE:	Years	Months	Days	If less than one day
	<u>17</u>	<u>8</u>	<u>4</u>	_____ min.

Due to _____

Due to _____

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

Other conditions: _____ (Include pregnancy within 3 months of death)

10. Usual occupation _____

Major findings: _____ Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name _____

13. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Sept 6 - 1940 (b) A. J. McDaniel (Date received local registrar) (Registrar's signature)

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

