

No. 2
-1-4-41
5-17-39
PI X2390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33719

FILED NOV 13 1941
Registration District No. 1002

Primary Registration District No. 1002

Registrar's No. 3650

1. PLACE OF DEATH:

(a) County Jackson Co Mo
(b) City or town Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Kansas City Tuberculosis Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr. 21 days
(Specify whether years, months or days)
In this community 47 yrs. 0

3. (a) PRINT FULL NAME Nova Austin

3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex Fem 3
5. Color of race Col. 0
6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased June 16 1894
(Month) (Day) (Year)

8. AGE: Years 47 Months 3 Days 8
If less than one day hr. min.

9. Birthplace Treming Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business None

12. Name Edward Austin

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

14. Maiden name Anna May
15. Birthplace Nashville Tenn
(City, town, or county) (State or foreign country)

16. (a) Informant K.S.T.C. Hospital

(b) Address Kansas City, Mo

17. (a) Burial (b) Date thereof 10/12/1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Western Cemetery
National Home

18. (a) Signature of funeral director

(b) Address 1520 N. 5th St

19. (a) 10/1/41 (b) M.M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 624 Charlotte
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 24
year 1941 hour 8:20 PM M.

21. I hereby certify that I attended the deceased from Sept. 3, 1940 to Sept. 24, 1941

that I last saw her alive on Sept 24, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death far advanced Pulmonary Tuberculosis
Duration

Due to
Due to

Other conditions Chronic Myocarditis
(Include pregnancy within 3 months of death)

Major findings: Of operations 136
Of autopsy

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 O. Hoyer, M.D. (M. D. or other) 9/24/41
Address K.S.T.C. Hospital Date signed 41

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

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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

Nathan W. Matheis

Licensed Embalmer No. *2700*

P. O. Address. *1520 N. 5th St.*

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, fact should be so stated above.