

FILED JAN 20 1942

Registration District No. \_\_\_\_\_

Primary Registration District No. 3010

Registrar's No. 12

1. PLACE OF DEATH

(a) County Cass  
(b) City or town Cassellton, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
South Side Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 79-1-8 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cass  
(c) City or town Cassellton  
(If outside city or town limits, write "RURAL")  
(d) Street No. 406 West 1st St  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Dr. Charles S. Austin

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

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced, married  
6. (b) Name of husband or wife Mattie M. Austin  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased (Month) 11 (Day) 10 (Year) 1862

8. AGE: Years 79 Months 1 Days 8  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Cassell County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Physician

11. Industry or business \_\_\_\_\_

12. Name Rev. Robert A. Austin

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

14. Maiden name Mattie E. Williams

15. Birthplace Cassellton Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mattie M. Austin

(b) Address Cassellton, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-41  
(Month) (Day) (Year)

(c) Place: burial or cremation Cass Hill Cem.

18. (a) Signature of funeral director Willis Marshall  
(b) Address Cassellton Mo

19. (a) 12-20-41 (Date received local registrar) (b) Mrs James R. Rafferty (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 18  
year 1941 hour 8 minutes 20 P. M.

21. I hereby certify that I attended the deceased from June 1, 1940  
\_\_\_\_\_ 19\_\_\_\_, to Dec 18, 1941  
\_\_\_\_\_ 19\_\_\_\_

that I last saw him alive on Dec 19, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Liver.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) H6

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 R. M. Keenan (M. D. number) M:AO  
Address Cassellton Mo Date signed 12-18-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

19  
1  
1

10-23

RECEIVED

District Health Officer No. 8,

District File Number

1-16-42

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 myself

....., Registered Apprentice No. ....

working under my personal supervision.

Signed P. M. Marshall

Licensed Embalmer No. 25-25

P. O. Address Carrollton Mo

**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.**