

FILED APR 15 1942

Registration District No. **246**

Primary Registration District No. **3038**

Registrar's No. **47**

1. PLACE OF DEATH:

(a) County **SALINE**
(b) City or town **MARSHALL CITY**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(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 or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **SALINE**
(c) City or town **Marshall**
(If outside city or town limits, write "RURAL")
(d) Street No. **E. West**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12th** day **March**
year **1942** hour **2:30** minute **P.** M.
21. I hereby certify that I attended the deceased from **March 7th** 1942 to **March 12** 1942
that I last saw him alive on **March 9th** 1942
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Nephritis**
Duration **Don't Know**

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **1318**

Major findings of operations _____
Of autopsy **L**
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) **L**
(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? **L** (Specify type of place) (e) Means of injury _____
23. Signature **W. W. Madison** (M. D. or other)
Address **Marshall, Mo.** Date signed **3-12-42**

3. (a) PRINT FULL NAME **JOHN AUSTIN**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **M** 5. Color or race **COL** 6. (a) Single, widowed, married, divorced **WIDOW**
6. (b) Name of husband or wife **EMMA AUSTIN** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Don't Know**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 70 _____ hr. _____ min.

9. Birthplace **SALINE MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **LABORER**

11. Industry or business _____

MOTHER FATHER { 12. Name **JAMES AUSTIN**
13. Birthplace **SALINE MO**
(City, town, or county) (State or foreign country)
14. Maiden name **BOURBIE**
15. Birthplace **SALINE MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **WILLIE AUSTIN**
(b) Address **414 E. WEST**

17. (a) **burial** (b) Date thereof **3-16-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MARSHALL**

18. (a) Signature of funeral director **J. P. Ferguson**
(b) Address **MARSHALL MO**

19. (a) **Mar 14 1942** (b) **M. T. O'Connell**
(Date received local registrar) (Registrar's signature)

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

97
1
2

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 4-14-42

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 _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed F. D. Ferguson

Licensed Embalmer No. 2172

P. O. Address Marshall

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.