

FILED FEB 11 1944

State File No.

Registration District No. 5-5

Primary Registration District No. 4082

Registrar's No. 6

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

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Boyard
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Home of J. B. Austin
(If not a hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 85 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME MOULIE AUSTIN

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married 2 divorced, widowed
6. (b) Name of husband or wife Howard Austin 6. (c) Age of husband or wife if alive 124 years
7. Birth date of deceased MAY 12th 1848
(Month) (Day) (Year)

8. AGE: Years 95 Months 7 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace Morrow County Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Berry Stevens
13. Birthplace Indiana (City, town, or county) (State or foreign country)
14. Maiden name Martha Hazelwood
15. Birthplace Indiana (City, town, or county) (State or foreign country)

MOTHER, FATHER

16. (a) Informant J. B. Austin
(b) Address Boyard Missouri
17. (a) Burial (b) Date thereof Jan 7 - 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ebenezer

18. (a) Signature of funeral director Clifford W. Austin
(b) Address Tena Missouri

19. (a) 1-7-1944 (b) Thomas R. Kelly
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 5th
year 1944 hour 6:30 minute _____ A.M.

21. I hereby certify that I attended the deceased from June 14th 1943, to Jan 5th 1944
that I last saw her alive on Jan 3rd 1944, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Senility

Due to Fracture of neck of left femur
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
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) Violence
(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) (c) Means of injury fall
23. Signature R. C. Cowherd (M. D. or other) D.O.
Address Carrollton, Mo. Date signed 1-6-43

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 2-8-44

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 Clifford W Austin

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, fact should be so stated above.

Registration District No. 05 Primary Registration District No. 4082 Registrar's No. 05

1. PLACE OF DEATH:
 (a) County Carroll
 (b) City or town Boysd
(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 years, months or days)

3. (a) PRINT FULL NAME Mollie Austin
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

7. Birth date of deceased May 12 1860
(Month) (Day) (Year)

8. AGE: Years 95 Months 7 Days 3 If less than one day _____ min.

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

10. Usual occupation _____
 11. Industry or business _____
 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month January Day 10 Year 1944 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
 that I last saw him/her _____ alive on _____ 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

semility
 Due to fracture of neck of left femur
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) Accident
 (b) Date of occurrence April 1st 1943 Honover
 (c) Where did injury occur? on farm in home of daughter Mrs. Wilbur Root Kansas
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 Home of daughter Mrs. Wilbur Root
 While at work? No (e) Means of injury dizzy spell
 23. Signature M. Cowherd (M. D. or other) DO
 Address Carrollton, Mo. Date signed 2-19-44

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

MOTHER FATHER

SUPPLEMENTAL

FEB 15 1944

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