

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

BUREAU OF THE CENSUS  
FILED JAN 24 1944

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 155

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Clayton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis County Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 month 13 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Pine Lawn  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3711 Salome  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Olivia Austin

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 2 Wid.

(b) Name of husband or wife Herbert Austin (Dec.) 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 11-22-1886  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
57 1 26 hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business --

12. Name Otto T. Colbnus  
13. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Agnes Khorn  
15. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant St. Louis Co. Hospital Record  
(b) Address Clayton, Missouri

17. (a) Burial (b) Date thereof Jan 30, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Zion Cemetery

18. (a) Signature of funeral director Shepard Funeral Home  
(b) Address 1167 Hamilton Avenue

19. (a) JAN 21 1944 (b) E. S. Mc Gowan, M.D.  
(Date received at local office) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1-17-44 day \_\_\_\_\_  
year \_\_\_\_\_ hour 5:55 minute A. M.

21. I hereby certify that I attended the deceased from 12-4-43 19\_\_\_\_ to 1-17-44 19\_\_\_\_  
that I last saw ER alive on 1-17-44 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation Duration 3 mos  
Due to Hypertension 7 yrs.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations None performed PHYSICIAN \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 \_\_\_\_\_  
Signature James G. Owen, M.D. (M. D. or other) \_\_\_\_\_  
Address 6011 Brentwood, Clayton Date signed 1-18

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

76  
2  
3

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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..... *W. W. Wilkins*

Licensed Embalmer No. .... *3575*

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.**