

FILED NOV 10 1944
318

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32021

State File No. _____

9301

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. _____

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 520 N. Spring
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Bradford Austin

3. (b) If veteran, name war None 3. (c) Social Security Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Fay Austin 6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased April 23 1900
(Month) (Day) (Year)

8. AGE: Years 44 Months 6 Days 9 If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER { 12. Name Lee Austin

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

14. Maiden name Bestia Crites

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

16. (a) Informant Fred Austin

(b) Address 3800 Olive St.

17. (a) Burial (b) Date thereof 11-3-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jackson, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) NOV 1 1944 (b) J. F. Brudick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 31
year 1944 hour 5:00 minute 5:00 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Atrophic myocarditis
Due to 93
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) _____
(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 3

23. Signature Albert H. Hoppe (M. D. or other) _____
Address _____ Date signed 11/1/44

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

OCT 1 1945

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 Albert G. Happe

Licensed Embalmer No. 2971

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.