

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

No. 2
5-42
17-39
X32873

FILED FEB 13 1945

Registration District No. 2335

Primary Registration District No. 5586

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Rural - Marion Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Route #3, Carthage
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper **49**
(c) City or town Rural - Marion Township **0**
(If outside city or town limits, write "RURAL")
(d) Street No. Route #3, Carthage **0**
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country (1)

3. (a) PRINT FULL NAME SIRENA EMILY AUSMAS

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 29, 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 6 13 _____ hr. _____ min.

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

10. Usual occupation Retd. School -teacher

11. Industry or business _____

MOTHER FATHER { 12. Name Samuel Ausmas
13. Birthplace X Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Patterson
15. Birthplace X Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ida Alexander
(b) Address Route #3, Carthage, Mo.

17. (a) Burial (b) Date thereof 1-13-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director Ed. C. Ulmer
(b) Address Carthage, Missouri

19. (a) Jan. 13, 1945 (b) E. Elizabeth Couplin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 11, year 1945 hour 11:00 minute A. M.

21. I hereby certify that I attended the deceased from Jan 4, 1945 to Jan 11, 1945; that I last saw her alive on Jan 4, 1945 and that death occurred on the date and hour stated above.
Immediate cause of death Acute Myocarditis Duration _____

Due to Bronchial Pneumonia

Due to Age

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: 107
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) _____
(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 _____

23. Signature J. E. Baker (M. D. or other) _____
Address Carthage Mo Date signed 1/13/45

1203

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

