V. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 12 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. X 5401

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 28

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Grim-Smith Hospital & Clinic
(If not in hospital or institution, give street address or location) Kirksville, Missouri
(d) Length of stay: In hospital or institution 8 hrs (Specify whether years, months or days)
In this community 8 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Macon 61
(c) City or town ~~Macon~~--Rural — La Plata
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME Mrs. Pauline Ausmus
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Fem 1
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Kenneth Ausmus
6. (c) Age of husband or wife if alive 26 years
7. Birth date of deceased ~~Not stated~~ 3-3-1924 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
20	11	20	hr. min.

9. Birthplace Macon County, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business XX
FATHER
12. Name Tom Faught
13. Birthplace Not known (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Not known
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. H. G. Crawford
(b) Address La Plata, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Hopewell Cemetery
18. (a) Signature of funeral director Hornbuckle
(b) Address Atlanta, Mo.
19. (a) 2-12-45 (Date received local registrar) (b) Mrs. L. Wayman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 11th year 1945 hour 6 minute 15 A. M.
21. I hereby certify that I attended the deceased from Feb. 10th, 1945 to Feb. 11, 1945 that I last saw him or her alive on Feb. 11th, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Conflagration--accidental	9 hrs
Due to: Complete incineration of upper extremities	9 hrs
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) Accident 061
(b) Date of occurrence 2/10/45
(c) Where did injury occur? Home (City or town) Macon Co. (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Farm Home (Specify type of place)
While at work? Yes (e) Means of injury explosion of kerosene
23. Signature E. S. Smith (M. D. or other)
Address Kirksville, Missouri Date signed 2/11/45

1047

(Licensed Embalmer's Statement on Reverse Side)

NOV 4 1949

RECEIVED
District Health Officer No. 10
District File Number 3-45-414
MAR 8 1945
Date Filed

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 H M Goodding, Registered Apprentice No. ....., working under my personal supervision.

Signed H M Goodding

Licensed Embalmer No. 1750

P. O. Address Atlanta Mo

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.