

FILED SEP 20 1948

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

29235

Registration District No. 74

Primary Registration District No. 6-293

Registrar's No. 33

## 1. PLACE OF DEATH:

- (a) County Clinton  
 (b) City or town Rural Atchison Twp  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

- (d) Length of stay: in hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community Entire Life  
years, months or days3. (a) PRINT FULL NAME Mary Lou Auxier

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
- Single

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

7. Birth date of deceased Nov. 20 1907  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
40 9 16 hr. \_\_\_\_\_ min.9. Birthplace Clinton Co. Mo.  
(City, town, or county) (State or foreign country)10. Usual occupation Housework

## 11. Industry or business \_\_\_\_\_

12. Name Thomas D. Auxier13. Birthplace Agency, Buchanan Co. Mo.  
(City, town, or county) (State or foreign country)14. Maiden name Annie Auxier15. Birthplace Albany Mo.  
(City, town, or county) (State or foreign country)16. (a) Informant Mr. Ethel Delaney(b) Address Howey Mo.17. (a) Burial (b) Date thereof Sept 8-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Allen Cem. Howey Mo.18. (a) Signature of funeral director A. A. Sullivan(b) Address Howey Mo.19. (a) Sept 8-1948 (b) Annie Chastain  
(Date received local registrar) (Registrar's signature) 386

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Clinton  
 (c) City or town Howey Rural  
 (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 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 6th  
year 1948 hour 11 minute 30a M.21. I hereby certify that I attended the deceased from 9-5  
1948, to 9-6- 1948that I last saw her alive on 9-5- 1948  
and that death occurred on the date and hour stated above.Immediate cause of death Coronary occlusion Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

## Major findings:

Of operations \_\_\_\_\_

Of autopsy 94A

## 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) (e) Means of injury D23. Signature J. E. Starks M.D. (M. D. 60th)Address Howey, Mo. Date signed 9-2-48

**DISTRICT HEALTH OFFICE**  
**Cameron, Mo.**

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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.....

*H. A. Sillins*

Licensed Embalmer No. *1738*

P. O. Address..... *Gower 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.**

Registration District No. 74 Primary Registration District No. 5293

1. PLACE OF DEATH:  
(a) County Clinton Rural  
(b) City or town \_\_\_\_\_  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Mary Lou Anxier  
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 S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Nov 20 1945  
(Month) (Day) (Year)

8. AGE: Years 40 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_  
min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo  
10. Usual occupation cleaning work + odd jobs  
last employed at Simp's St. Joseph

MOTHER FATHER { 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) Sept 29 (b) Emilee Chastain  
(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 10 Day 15 Year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
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) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

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

TEMPORARILY

S-29235