

FILED OCT 20 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33419

State File No.

4152

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>KANSAS</u> b. COUNTY <u>JOHNSON</u>				
b. CITY (If outside corporate limits, write RURAL and give town) <u>KANSAS CITY</u>		c. LENGTH OF STAY (in this place) <u>1 day</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Stilwell</u>		<u>8150</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST MARY'S HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>X</u>				
3. NAME OF DECEASED a. (First) <u>Robert</u>			b. (Middle) <u>Walter</u>		c. (Last) <u>Austin</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 28 1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Nov-24-1891</u>		9. AGE (In years last birthday) <u>59</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Underwriter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brace Dadsen Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Alexandria Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>ROBERT AUSTIN</u>			13b. MOTHER'S MAIDEN NAME <u>MARTHA JONES</u>		14. NAME OF HUSBAND OR WIFE <u>MRS. EVE AUSTIN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WORLD WAR I</u>		16. SOCIAL SECURITY NO. <u>486-07-7552</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS. EVE AUSTIN Stilwell Kansas</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Aneurysm of abdominal aorta</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>With spontaneous rupture</u> DUE TO (c) <u>Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u> <u>451X</u>	
19a. DATE OF OPERATION <u>9/27/51</u>		19b. MAJOR FINDINGS OF OPERATION <u>Abdominal and retroperitoneal hemorrhage</u>					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY)		21d. (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>Pathologist</u> , to _____, 19____, that I last saw the deceased <input checked="" type="checkbox"/> alive on _____, 19____, and that death occurred at <u>11:48 A m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>Angelo Lapi M.D. Pathologist</u> (Degree or title)				23b. ADDRESS <u>101 Memorial Drive</u>		23c. DATE SIGNED <u>9/29/51</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>OCT-1-1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>FLORAL HILLS CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>		
DATE REC'D BY LOCAL REG. <u>10-1-51</u>		REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>S. H. Newcomer, Sons Kansas City, Mo.</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

MAY 20 1952

MAY 8 1952

MAY 6 1951 AON

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed..... *John R. Sidman*

Signed.....
Student Embalmer

Licensed Embalmer No. *4531*

P. O. Address *Kansas City*

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.