

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028248
STATE FILE NUMBER

FILED AUG 25 1958 Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 887

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph 0117 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hosp.		Length of stay in lb 50 yrs.	d. STREET ADDRESS (If outside, give location) 218 W. Isabelle Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JOHN Middle J. Last AUGUSTINE			4. DATE OF DEATH Month August Day 15, Year 1958		
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 4, 1893	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Fireman		10b. KIND OF BUSINESS OR INDUSTRY City Fire Dept.	11. BIRTHPLACE (City and state or country) Andrew Co., Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John J. Augustine		13b. MOTHER'S MAIDEN NAME Sarah Carter		14. NAME OF HUSBAND OR WIFE Oma Augustine	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 300-297-7432	17. INFORMANT Address Oma Augustine, 218 W. Isabelle, St. Joseph, Mo		
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 12 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____		
		DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
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20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
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21. I attended the deceased from 9 P.M. 8-14-58 to 8-15-58 and last saw her alive on 8-14-58 Death occurred at 4:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
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22a. SIGNATURE Dr. H. H. ... (Degree or title)			22b. ADDRESS St. Joseph		22c. DATE SIGNED 8-15-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/18/58	23c. NAME OF CEMETERY OR CREMATORY Long Branch Cemetery		23d. LOCATION (City, town, or county) (State) Andrew County, Missouri
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24. FUNERAL DIRECTOR Heaton-Burman		ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Aug 16, 1958	26. REGISTRAR'S SIGNATURE Mrs. Clark Handell	
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Dr. L. H. Faison, M.D.
Hillparkville Bldg -

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *John V. Herrick Jr.*
Licensed Embalmer No. *4848*
P. O. Address *H. G. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.