

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

SEP 9 1935

25755

1. PLACE OF DEATH

County Callaway Registration District No. 104
 Township Primary Registration District No. 3008
 City Fulton (No., St. Ward)

2. FULL NAME Musgrove, Samuel

(a) Residence, No. State Hospital # 1 St. Ward.
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF D. K.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) D. K.

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
About 67 2 28

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) D. K. 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Callaway County, Mo.

13. NAME D. K.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME D. K.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT Hospital Records (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE White Cloud Cemetery DATE Aug. 18 1935

19. UNDERTAKER M. J. Wallace (ADDRESS) 7 1/2 St.

20. FILED Aug 17 1935 R. N. Crews Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 16, 1935

22. I HEREBY CERTIFY, That I attended deceased from July 4, 1935, to August 16, 1935

I last saw him alive on 2 AM Aug. 16, 1935 Death is said to have occurred on the date stated above, at 8:04 A. M.

The principal cause of death and related causes of importance were as follows:

Broncho Pneumonia Date of onset 8/15/35

Other contributory causes of importance:
Senility
Tuberculosis

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....

Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

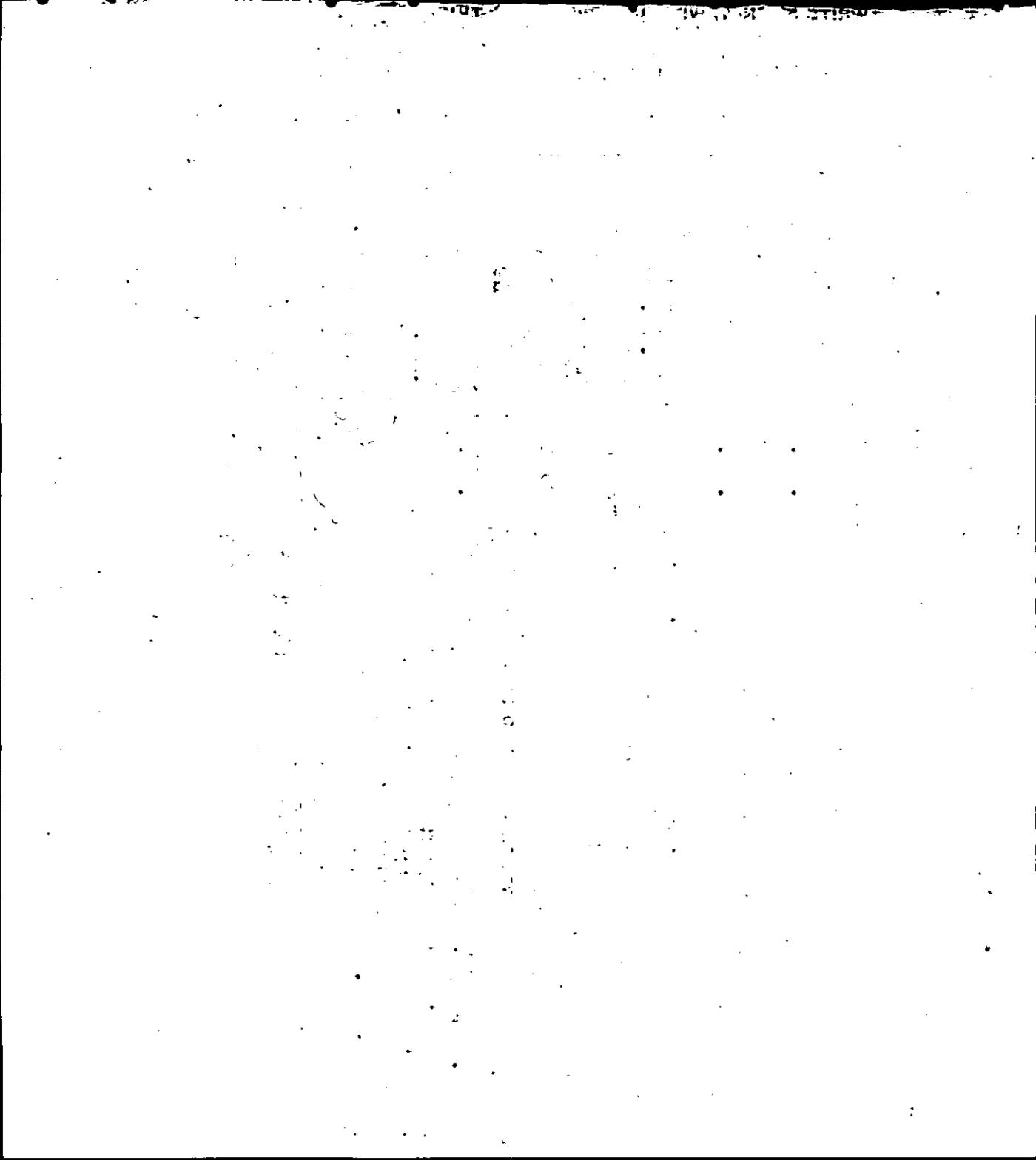
Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify

(Signed) E. E. Landis, M. D.
 (Address) Fulton, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



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ALL INFORMATION CALLED FOR MUST BE ENTERED ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Callaway

Registration District No. 104

File No. 25755

Township

Primary Registration District No. 3008

Registered No. _____

City Fulton

(No. State Hosp. # 1)

St. _____ Ward _____

2. FULL NAME Musgrove Samuel

(a) Residence, No. _____ St. _____ Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) w

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as splinter, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19__

19. UNDERTAKER (ADDRESS)

20. FILED Aug 17 1935 R. N. Crews Registrar.

MEDICAL CERTIFICATE OF DEATH

1. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 16 1935

I HEREBY CERTIFY, That I attended deceased from July 4 1935 to Aug 16 1935

I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at 8:45 am.

The principal cause of death and related causes of importance were as follows:

Bronchitis pneumonia Date of onset _____

Other contributory causes of importance: Sensitivity

Tuberculosis (Pulmonary)

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____

(Signed) E. C. Landis, M. D.
(Address) Fulton Mo

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5-25755