

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

Do not use this space.

JAN 13 1936

41833

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... (No. **St. John's Hosp.**)..... St. Ward.....

File No. **11135**
Registered No.

2. FULL NAME

John David Musgrave
(a) Residence, No. St. **N.R.** Ward. **Crystal City Mo**
(Usual place of abode)
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 **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Tina Dale Musgraves**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Nov 19 1873**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 1 9

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **merchant**
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)..... **Salem Mo**
(STATE OR COUNTRY)

FATHER 13. NAME **Cook Musgraves**

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

MOTHER 15. MAIDEN NAME **Bessie**

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

17. INFORMANT **Mrs John D Musgraves**
(ADDRESS) **Crystal City Mo**

18. BURIAL, CREMATION, OR REMOVAL **Salem Cemetery** DATE **Jan 1** 19**36**

19. UNDERTAKER **Fraunce V. Baruch**
(ADDRESS) **Crystal City Mo**

20. FILED **DEC 30 1935** **J.H. Bredbeck**
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **12/29/35**

22. I HEREBY CERTIFY, That I attended deceased from **12/28/35**, 19..... to **12/29/35**, 19.....

I last saw ~~him~~ alive on **12/29/35**, 19..... Death is said to have occurred on the date stated above, at **8:30 a.m.**
The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage
Hemiparesis
Other contributory causes of importance: **174 lb**
Date of onset **(3)**

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?

If so, specify.....

(Signed) **O.H. Falk** M. D.
Beaumont Kelly
(Address).....

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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