

SEP 17 1937

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

Do not use this space.

1. PLACE OF DEATH

County Dent Registration District No. 266 File No. 30559  
Township \_\_\_\_\_ Primary Registration District No. 4164 Registered No. 60  
City Salem (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME John Musgraves

(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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 3 1840

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
97 5 23

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

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) Pulaski Co  
(STATE OR COUNTRY) Mo

13. NAME D.K.

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

15. MAIDEN NAME D.K.

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

17. INFORMANT Roy Musgrave  
(ADDRESS) Salem Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Blackwell Cem DATE \_\_\_\_\_

19. UNDERTAKER Carl K Spencer  
(ADDRESS) Salem Mo

20. FILED Aug 27 1937 F E Dauter M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 26 1937

22. I HEREBY CERTIFY, That I attended deceased from Aug 24, 1937, to Aug 26, 1937  
I last saw him alive on Aug 25, 1937 Death is said to have occurred on the date stated above, at 9 A.M.

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

Pneumonia, lobar

Date of onset Aug 24

Other contributory causes of importance:

Name of operation none Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

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) John E. Griffith M. D.

(Address) Salem, Mo.

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.



FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

30539

Do not use this space.

1. PLACE OF DEATH
- (a) County Dent Registration District No. 266
- (b) Township \_\_\_\_\_ Primary Registration District No. 4164 Registered No. 60
- (c) City Salem (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_
- (e) Length of residence in city or town where death occurred \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number)
2. PRINT FULL NAME John Musgraves
- (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (wid)
- 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. |
|        | <u>97</u> | <u>5</u> | <u>23</u> |  |
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_
9. Industry or business in which work was done, as 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) \_\_\_\_\_
- FATHER
13. NAME \_\_\_\_\_
14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_
- MOTHER
15. MAIDEN NAME \_\_\_\_\_
16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_
17. INFORMANT (ADDRESS) \_\_\_\_\_
18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE Aug 30 1937
19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_
20. FILED Aug 27 1937 G. E. Joseph M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 26 1937
22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.
- I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the day certified above, at \_\_\_\_\_ m.
- The principal cause of death and related causes of importance were as follows:
- Pneumonia Lobar Date of onset \_\_\_\_\_
- Other contributory causes of importance: \_\_\_\_\_
- Name of operation \_\_\_\_\_ Date of \_\_\_\_\_
- What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_
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) G. E. Joseph M. D. (Address) Salem

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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.

S-30559