

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

41018  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Sullivan Registration District No. 953  
 (b) Township Bellevue Primary Registration District No. 4519  
 (c) City Newtown (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Catharine Musgrave  
 (a) Residence, No. Newtown St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OF (OR) WIFE OF Alexander M. Musgrave

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-24-1850

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>89</u>	<u>3</u>	<u>09</u>	

OCCUPATION

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

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 \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 2, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 10, 1939, to Nov. 2, 1939  
 I last saw her alive on Nov. 2, 1939 Death is said to have occurred on the date stated above, at 10:30 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Chronic Myocarditis Date of onset \_\_\_\_\_

Other contributory causes of importance: None

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

FATHER

13. NAME Samuel Yambert  
 14. BIRTHPLACE (CITY OR TOWN) Penn. (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME Margaret Bierly  
 16. BIRTHPLACE (CITY OR TOWN) Ohio (STATE OR COUNTRY)

17. INFORMANT A. R. Musgrave (ADDRESS) Newtown

18. BURIAL, CREMATION, OR REMOVAL PLACE Newtown DATE Nov. 5, 1939

19. FUNERAL DIRECTOR (NAME) Judd + Payne (ADDRESS) Newtown

20. FILED Nov. 13, 1939 Mrs. Ruth Tucker Local Registrar.

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? No  
 If so, specify \_\_\_\_\_  
 (Signed) E. A. Dale M. D.  
 (Address) Newtown

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD 065  
 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.

REC'D DEC 18 1939

RECEIVED

District Health Officer No. 10

District File Number 12-39-2107

Date Filed DEC 11 1929

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.