

MAD 14 1941 98  
Registration District No. 198

Primary Registration District No. 3011

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town Excelsior Spring  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Excelsior Spring  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Earl Eby Mick

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov. 29, 1908  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>32</u>	<u>2</u>	<u>5</u>	hr. _____ min.

9. Birthplace Clay Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Dayton Mick  
13. Birthplace Holt Mo. O  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Emma Eby  
15. Birthplace Texas  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Dayton Mick  
(b) Address Refractory

17. (a) \_\_\_\_\_ (b) Date thereof Feb 6 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cutoch

18. (a) Signature of funeral director Edward Fry  
(b) Address Excelsior Spring Mo

19. (a) 2-14-1941 (b) Mr. R. M. Cracker  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County CLAY 24  
(c) City or town Kearney 0  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 4 in year 1941 hour 4 minute 45 A. M.

21. I hereby certify that I attended the deceased from 7/1/41 to 2/4/41, 19\_\_\_\_; that I last saw him alive on 2/4/41, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death acute Cardiac failure

Due to mediastinal infection

Due to severe contusions to chest with sternal - rib fracture

Other conditions (Include pregnancy within 3 months of death) dislocated rt. clavicle

Major findings: Of operations \_\_\_\_\_

Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 2/1/41

(c) Where did injury occur? Excelsior Spring, Clay Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? public highway  
While at work yes (Specify type of place) (e) Means of injury motor car

23. Signature David E. Muegner (M. D. or other) P  
Address Excelsior Spring, Mo Date signed 2/4/41

Duration

in weeks

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING INK—STATE FULL NAME AND OCCUPATION IN PLAIN TERMS. 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.

17026  
957

1288

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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 Leland Jay

Licensed Embalmer No. 1677

P. O. Address Kearney, 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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

6670  
Do not use this space.

PLACE OF DEATH

(a) County Clay Registration District No. 198  
 (b) Township Excelsior Springs Primary Registration District No. 3011 Registered No. \_\_\_\_\_  
 (c) City Excelsior Springs Street No. \_\_\_\_\_  
 (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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Earl Fly Micko

(a) Residence, No. \_\_\_\_\_ 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 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.  
32 2 5

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)

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 4 1941

22. I HEREBY CERTIFY That I attended deceased from Feb 1 to Feb 4 1941

I last saw him alive on Feb 9 1941. Death is said to have occurred on the date stated above, at 2:30 p.m.

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

Cardiac failure  
mediastinal infection  
Severe contusion to chest with rib fracture  
Dislocated st. clavicle

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? acc Date of injury 2-1 1941

Where did injury occur? Excelsior Spgs Mo

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Public Place, State maintained

Nature of injury collision with another auto

Crushed chest

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) David H. Prosser, M. D.

(Address) Excelsior Spgs, Mo

SUPPLEMENT

Musgrave (M.D.) Excelsior Spgs 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

