

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 11 1942
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3289

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mobison Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days
(Specify whether
In this community 30 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL.")
(d) Street No. 3619 Cherokee
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Hattie W Musgrave
(b) If veteran, name war no (c) Social Security No. 210

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 9-4-42 day _____ year _____ hour _____ minute 9:05 A.M.

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Phillip Musgrave 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 8 1865
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from August 19 1942 to Sept 4 1942
that I last saw h.e.a. alive on 9-3 and that death occurred on the date and hour stated above.

Immediate cause of death Lobor pneumonia Duration 3 days

8. AGE: Years 77 Months 3 Days 26 If less than one day _____ hr. _____ min.

Due to constant confinement to bed because of a fractured hip

9. Birthplace New York
(City, town, or county) (State or foreign country)

Other conditions 1865
(Include pregnancy within 3 months of death)

10. Usual occupation at home

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
11. Industry or business _____
12. Name James C Caldwell
13. Birthplace N.Y.
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Taylor
15. Birthplace N.Y.
(City, town, or county) (State or foreign country)

16. (a) Informant Pearl W. Hayward
(b) Address 3619 Cherokee

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Acc.
(b) Date of occurrence April 1942
(c) Where did injury occur? K 6 123 mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
(Specify type of place)
While at work? _____ (e) Means of injury Acc. fall

17. (a) Cremation (b) Date thereof Sept 5 1942
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Elmwood Cem

18. (a) Signature of funeral director Wm. C. Foster
(b) Address 918 Brooklyn
19. (a) 9-4-42 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

23. Signature Bessie Johnson (M. D. or other) _____
Address 2625 Pass. Date signed 9-4-42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAY 15 1953

[Faint handwritten notes and scribbles, possibly including "to care of" and "Name"]

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 *me*

Registered Apprentice No. _____

working under my personal supervision.

Signed *G. J. [unclear]*

Licensed Embalmer No. *2570*

P. O. Address *Kansas City 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, fact should be so stated above.