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5-42  
17-39  
X32873

Miss. 33179

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED NOV 10 1942

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 38

Primary Registration District No. 3006-5120

Registrar's No. 237

1. PLACE OF DEATH:  
(a) County Boone  
(b) City or town Columbia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Boone County Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 Day (Specify whether  
In this community 23 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Boone  
(c) City or town Columbia  
(If outside city or town limits, write "RURAL")  
(d) Street No. 609 Turner Ave.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ANN ELIZA MUSICK  
3. (b) If veteran, name war None  
3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct. day 25  
year 1942 hour 12:30 minute P. M.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Virgil M. Musick  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 2 - 4 - 1863  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 10-18 to 10-25 1942  
that I last saw her alive on 10-25 1942  
and that death occurred on the date and hour stated above.  
Immediate cause of death Pneumonia Duration 3 days

8. AGE: Years 79 Months 8 Days 21  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Age & General Debility  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace Jamestown Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation At Home

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

11. Industry or business \_\_\_\_\_  
12. Name H.H. Hudson  
13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name Eliza Boggs  
15. Birthplace Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant Edna Jane Musick  
(b) Address 609 Turner, Columbia, Mo.  
17. (a) Burial (b) Date thereof 10-27-42  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park Cemetery  
18. (a) Signature of funeral director Charles F. Deane  
(b) Address Columbia, Mo.  
19. (a) 10-26-42 (b) Edna J. Barber  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature F. B. Williamson (M. D. or other) \_\_\_\_\_  
Address Columbia Mo Date signed 10/26/42

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

**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

*W. A. McRitchey*

Licensed Embalmer No.

*3893*

P. O. Address

*Columbia me*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33179  
Registrar's No. 237

Registration District No. 38 Primary Registration District No. 3006

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ann Chyazmusich  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Year 1942 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death Pneumonia  
in bacterial

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Feb 4 (Month) (Day) (Year)

Duration  
Due to age - generalized  
debility  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: 107  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years 79 Months 8 Days 10 If less than one day \_\_\_\_\_ min.  
9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) me

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(b) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature F. B. Williams (M. D. or other) \_\_\_\_\_  
Address Columbia, Mo Date signed 2-11-42

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

SUPPLEMENTARY

MOTHER FATHER

