

S. No. 2
DM-2-43
v. 5-17-39
- I X 3

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9303

State File No. _____

2642

FILED MAR 27 1944

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2339 A Howard St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Calvin Musgrove

3. (b) If veteran, name was None
3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 2 Widowed

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

7. Birth date of deceased July 24 1869
(Month) (Day) (Year)

8. AGE: Years 74 Months 7 Days 24 If less than one day hr. _____ min. _____

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

10. Usual occupation Night Watchman

11. Industry or business _____

12. Name Eden

13. Birthplace Illinois (City, town, or county) (State or foreign country)

14. Maiden name Roster

15. Birthplace Illinois (City, town, or county) (State or foreign country)

16. (a) Informant John D Musgrove

(b) Address 2339 A Howard St.

17. (a) Burial (b) Date thereof 3 / 20 / 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director A W M Laughlin
(b) Address 2301 Lafayette Ave.

19. (a) MAR 20 1944 (Date received local authority) J. J. Bredesch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 18
year 44 hour 8 minute 48 AM

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Generalized Arteriosclerosis

Due to Senility

Due to 97

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

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Thomas P. Collins (M. D. or other) _____

Address Deputy Coroner Date signed 3-20-44

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.....

L R Cooper

Licensed Embalmer No. *3632*

P. O. Address. *2317 Lafayette*

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.