

FILED JUL 30 1945

Registration District No. 22

Primary Registration District No. 1000

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

1. PLACE OF DEATH:

(a) County Shelburne

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution State Hospital # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 26 yrs 2 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town N.C.
(If outside city or town limits, write "RURAL")

(d) Street No. —
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME THOMAS MUSTAIN

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24 year 1945 hour 18 minute 0 M.

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased: May 27 1888
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 23 1945 to July 24 1945 that I last saw him alive on July 24 1945 and that death occurred on the date and hour stated above.

8. AGE: Years 57 Months 7 Days 7 If less than one day hr. _____ min. _____

Immediate cause of death Pulmonary Edema

Due to Myocarditis

9. Birthplace Lora (City, town, or county) (State or foreign country) 1

10. Usual occupation mail clk

Due to _____

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

MOTHER FATHER

11. Industry or business _____

12. Name Theron Mustain

13. Birthplace Ill (City, town, or county) (State or foreign country) 1

14. Maiden name Kate Griffin

15. Birthplace Ill (City, town, or county) (State or foreign country) 1

Major findings: Of operations _____

Of autopsy _____

16. (a) Informant Frank W. Land
(b) Address K.C. Mo

17. (a) Cremation (b) Date thereof 7-27-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation K.C. Mo

PHYSICIAN

Underline the cause to which death should be charged statistically.

18. (a) Signature of funeral director Freeman & Son Inc
(b) Address At Smith, Mo

19. (a) 7-27-45 (b) John O. Peck
(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 J. J. Smith (M. D. or other) _____
Address St. Joseph, Mo Date signed 7/24/45

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

Robert H. Gayle

Licensed Embalmer No.

3308

P. O. Address

St Joseph, 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.