. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 19 1947

Registration District No. 119

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34176

Primary Registration District No. 418-95437

Registrar's No. 73

1. PLACE OF DEATH:
(a) County: Gasconade
(b) City or town: Rosebud - rural
(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 years, months or days)
In this community: 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Gasconade
(c) City or town: Rosebud - rural
(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: Charles A. Muir
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Laura Muir
6. (c) Age of husband or wife if alive: 59 years
7. Birth date of deceased: March 30, 1870 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
77	6	13	____ hr. ____ min.

9. Birthplace: Sullivan, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business ____
FATHER
12. Name: Horace Muir
13. Birthplace: Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)
16. (a) Informant: Belva Muir
(b) Address: Union, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/15/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Bethel Cemetery
18. (a) Signature of funeral director: E. J. Meyer
(b) Address: Gerald Mo
19. (a) 11/12/47 (Date received local registrar) (b) Dorothy Hackman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: October day: 13 year: 1947 hour: 3:40 minute: P. M.

21. I hereby certify that I attended the deceased from January 10, 1946 to October 13, 1947 that I last saw him alive on October 13, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Congestive Heart Failure Acute	20 days
Due to: Valvular Heart disease (Mitral)	
Due to: Myocarditis chronic	
Other conditions (include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN
Underline the cause of 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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature: B. J. Macauley (M. D. or other)
Address: Gerald Mo Date signed: 11-11-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 me, Registered Apprentice No., working under my personal supervision.

Signed Earl C. Ferling

Licensed Embalmer No. 33085

P. O. Address New Haven 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.