

FILED DEC 6 1947
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2622 Lafayette Avenue
(If not in hospital or institution, write street number or location),
(d) Length of stay: In hospital or institution **23 years** (Specify whether 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. **2622 Lafayette Avenue**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **ALBERT WEBSTER MUSGROVE**
3. (b) If veteran, name war **N11**
3. (c) Social Security No. **499-01-6921**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **21** year **1947** hour **12:40** minute **a** M.
21. I hereby certify that I attended the deceased from **June 21, 1947** to **Nov 20, 1947**
that I last saw him alive on **11-20-47** and that death occurred on the date and hour stated above.

4. Sex **M** **5. Color or race** **W**
6. (a) Single, widowed, married, divorced **M**
6. (b) Name of husband or wife **Aileen**
6. (c) Age of husband or wife if alive **38** years
7. Birth date of deceased **April 26, 1904**
(Month) (Day) (Year)

Immediate cause of death
Carcinoma of Colon
Duration **6 mos**

8. AGE: Years **43** Months **6** Days **24** If less than one day hr. min.

Due to
Other conditions **None**
(Include pregnancy within 3 months of death)

9. Birthplace **Marvell, Arkansas**
(City, town, or county) (State or foreign country)
10. Usual occupation **Truck driver**

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 **John C. Musgrove**
13. Birthplace **Murphysboro, Illinois**
(City, town, or county) (State or foreign country)
14. Maiden name **Winnie Abels**
15. Birthplace **Macon, Georgia**
(City, town, or county) (State or foreign country)
16. (a) Informant **Aileen Musgrove**
(b) Address **2622 Lafayette Avenue**
17. (a) burial (Burial, cremation, or removal) **(b) Date thereof** **11/22/47**
(Month) (Day) (Year)
(c) Place: burial or cremation **New St. Marcus Cemetery**
18. (a) Signature of funeral director **A.W. McLaughlin**
(b) Address **2301 Lafayette Avenue**
19. (a) NOV 21 1947 (Date received local registrar) **(b) J.F. Bredenk** (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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature **F.J. Swebosky** (M. D. or other) **MD**
Address **25028 50 Jefferson** **Date signed** **11-21-47**

Dr. Frank J. Swecosky
2528a So. Jefferson

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..... *R W Cooper*

Licensed Embalmer No. *3930*

P. O. Address *30 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.