

FILED AUG 31 1954

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **26991**

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>14</u>	
1. PLACE OF DEATH a. COUNTY <u>Howell Co.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains</u>		c. LENGTH OF STAY (In this place) <u>life</u>		c. CITY OR TOWN <u>West Plains</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>919 Grace Ave.</u>				e. STREET ADDRESS (If rural, give location) <u>0066/0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u>			b. (Middle) <u>STANFORD</u>		c. (Last) <u>MUSTION</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 11, 1954</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>divorced</u>	8. DATE OF BIRTH <u>May 13, 1871</u>		9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer-Stockman</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Howell Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>J. V. Mustion</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Copeland</u>		14. NAME OF HUSBAND OR WIFE <u>Julia Mustion</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Clyde Mustion Marmoth Spg., Ark.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u>					
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>					
		DUE TO (c) <u>Senility</u>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>4201</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>West Plains Howell Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Sept 2, 1953</u> to <u>8/11, 1954</u> , that I last saw the deceased alive on <u>7-2</u> , 19 <u>54</u> , and that death occurred at <u>7:45 am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u> (Degree or title) _____				23b. ADDRESS <u>West Plains Mo</u>		23c. DATE SIGNED <u>8/20/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/15/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Homeland Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>West Plains Mo.</u>		
DATE REC'D BY LOCAL REG. <u>8-24-54</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		379- FISCAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	

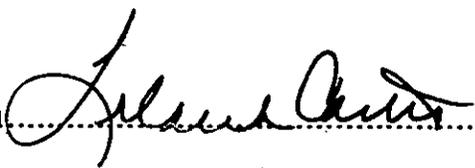
(Licensed Embalmer's Statement on Reverse Side)

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

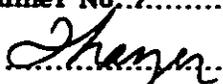
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....


Licensed Embalmer No. 757

P. O. Address.....


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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.