

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26367**
3779

FILED SEP 14 1955

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 7 YRS		e. STREET ADDRESS (If rural, give location) 2815 Troost	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1		3428	

3. NAME OF DECEASED (Type or Print)	a. (First) John	b. (Middle) M.	c. (Last) Musteen	4. DATE OF DEATH (Month) (Day) (Year) 8 25 1955
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIV	8. DATE OF BIRTH JULY 9 1891	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) SPRINGDALE, ARK	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME BILL MUSTGEN	13b. MOTHER'S MAIDEN NAME NELLIE	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI	16. SOCIAL SECURITY NO. 491-01-0200	17. INFORMANT'S SIGNATURE OR NAME JEAN A ELLIOT	ADDRESS 2815 TROOST
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anemia		
	ANTECEDENT CAUSES DUE TO (b) Emaciation DUE TO (c) Carcinoma of esophagus with metastases to lungs Cirrhosis of liver		150 h
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	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Aug. 2, 1955, to Aug. 26 25, 1955, that I last saw the deceased alive on Aug. 26 25 1955, and that death occurred at 10:55A., from the causes and on the date stated above.

23a. SIGNATURE B.I. Burns M.D.	(Degree or title) D	23b. ADDRESS 24th & Cherry	23c. DATE SIGNED 8-26-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) REM	24b. DATE 8-27-55	24c. NAME OF CEMETERY OR CREMATORY MT CALVARY CEM	24d. LOCATION (City, town, or county) (State) K.C. KANS.
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DATE REC'D BY LOCAL REG. 8-27-55	REGISTRAR'S SIGNATURE Neva Marshall	25. FUNERAL DIRECTOR'S SIGNATURE SEBETO	ADDRESS K.C. Mo.
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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..... *Forest D. Golds...*

Licensed Embalmer No..... *471*

P. O. Address..... *KC 7*

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.