

FILED JAN 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3325

STATE FILE NUMBER

Registration District No. 323 Primary Registration District No. 4474 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY <u>SALINE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>SALINE</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SWEET SPRINGS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>SWEET SPRINGS 6910</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>236 BRIDGE ST</u>			Length of stay in 1b <u>3 MONTHS</u>	d. STREET ADDRESS (If outside, give location) <u>236 BRIDGE ST.</u>			Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>EVERETT</u> Last <u>MUSGRAVE</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 11, 1894</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAPTIST MINISTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHURCH</u>		11. BIRTHPLACE (City and state or country) <u>ANNA ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ANDREW MUSGRAVE</u>				14. MOTHER'S MAIDEN NAME <u>AMANDA GRACE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WORLD WAR I</u>		16. SOCIAL SECURITY NO. <u>086-10-3660</u>		17. INFORMANT Address <u>MRS. J. E. MUSGRAVE, SWEET SPRINGS, MO.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer spread to vital organs</u>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c) <u>Cancer prostate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>17.7X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>11:30</u> Month, Day, Year <u>1-14-57</u> a. m. <u>00</u> p. m. <u>00</u>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>1-31-56</u> to <u>1-10-57</u> and last saw ^{her} him alive on <u>1-10-57</u> Death occurred at <u>1-14-57 11:30m</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>J. H. Hale M.D.</u> (Degree or title)				22b. ADDRESS <u>Sweet Springs Mo</u>		22c. DATE SIGNED <u>1-15-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-17-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEMETERY</u>		23d. LOCATION (City, town, or county) <u>KANSAS CITY</u>		STATE <u>Missouri</u>	
24. FUNERAL DIRECTOR <u>E. S. Yarns</u>			ADDRESS <u>Concordia Mo</u>	25. DATE RECD. BY LOCAL REG. <u>JANUARY 15, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Mary Moseley</u>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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1-56Health,
Welfare
Public
Service

JAN 22 1957

JAN 8 1957

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed E. S. James
Licensed Embalmer No. 205
P. O. Address Concordia

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.

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