

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1500

FILED MAR 29 1957

STATE FILE NUMBER

Registration District No.

317

Primary Registration District No.

590

Registrar's No.

679

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN Valley Park 4 Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Crestwood 4790 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Moll Nursing Home Length of stay in 1b 10 days		d. STREET ADDRESS (If outside, give location) 9311 Watson Rd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) James Lee Magruder <i>First Middle Last</i>			4. DATE OF DEATH March 10, 1957 <i>Month Day Year</i>		
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1862		9. AGE (In years last birthday) 94
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and state or country) Foley, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Wm. Magruder			14. MOTHER'S MAIDEN NAME Phemia Burkhead		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Frieda Magruder, 9311 Watson Rd <i>Address</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage (left)		INTERVAL BETWEEN ONSET AND DEATH 10 hrs	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DOE TO (b) Arteriosclerotic vascular disease		chr.
	DOE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	

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 12:45 Month, Day, Year a. m. p. m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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 **July 15 1957** to **Mar 10 1957** and last saw ^{him} **Mar 8 1957** alive on **Mar 8 1957**
Death occurred at **12:45** p. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. Heubaugh M.D.	22b. ADDRESS 105 W. Lockwood Ave Webster Groves Mo.	22c. DATE SIGNED 3/11/57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/10/57	23c. NAME OF CEMETERY OR CREMATORY Troy Cem.	23d. LOCATION (City, town, or county) (State) Troy, Mo.
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24. FUNERAL DIRECTOR ADDRESS McCoy Funeral Home, Troy, Mo.	25. DATE RECD. BY LOCAL REG. 3/12/57	26. REGISTRAR'S SIGNATURE Herbert A. Donke MD
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(Licensed Embalmer's Statement on Reverse Side)

S. 300
V. 1-56

securing the medical certification in the specific manner required by 193.140 MO. REV. 1949.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

27.

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.....
Ben Hoffman

Licensed Embalmer No. *436*

P. O. Address.....
St Louis

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.