

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37917

STATE FILE NUMBER

FILED OCT 29 1957

Registration District No. 318 Primary Registration District No. 1003

Registrator's 9775

Health,
Welfare
Public
Service

300
1-56

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO</i> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>CHRISTIAN HOSP.</i>		Length of stay in 1b <i>28 YRS</i>		d. STREET (If outside, give location) ADDRESS <i>5205 N. BROADWAY</i>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>ANNA</i> First <i>C.</i> Middle <i>MUSGROVE</i> Last			4. DATE OF DEATH Month <i>OCT.</i> Day <i>17</i> Year <i>1957</i>					
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>JULY 8. 1890</i>	9. AGE (In years last birthday) <i>67</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NIL</i>		11. BIRTHPLACE (City and state or country) <i>MOUNTAIN VIEW, MO.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>JOHN CUPLER</i>				14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT <i>JOHN MUSGROVE</i> Address <i>5205 N. BROADWAY</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) <i>Hypertensive heart disease</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Generalized Arterio-sclerosis</i> DUE TO (c) <i>Pleural effusion right</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>443x</i>						INTERVAL BETWEEN ONSET AND DEATH <i>April 1954</i> <i>" "</i> <i>3 mo.</i>		
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 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 <i>April 23, 1954</i> to <i>Oct 17, 1957</i> and last saw her alive on <i>Oct 17, 1957</i> . Death occurred at <i>9:15 A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>[Signature]</i> (Degree or title)				22b. ADDRESS <i>4222 N. Grand</i>		22c. DATE SIGNED <i>10-18-57</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<i>REMOVAL</i>		<i>OCT. 19. 1957</i>	<i>MEMORIAL PARK CEM</i>		<i>ST. LOUIS CO MO</i>			
24. FUNERAL DIRECTOR <i>Wiedmeyer & Sons 3934 N. 20th</i> ADDRESS				25. DATE RECD. BY LOCAL REG. <i>OCT 18 '57</i>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

(Licensed Embalmer's Statement on Reverse Side)

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 *Gustav W. Dieter*.....

Licensed Embalmer No. *43*

P. O. Address *St. Louis*

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.