

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001802

STATE FILE NUMBER

Registration District No. 160 Primary Registration District No. 3029 Registrar's No. 4
FILED JAN 14 1959

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JEFFERSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CRYSTAL CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>1000 MISS. AVE.</u> ⁰⁵⁶¹ 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>At Home</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>CRYSTAL CITY</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>TINA</u> Middle <u>DALE</u> Last <u>MUSGRAVES</u>			4. DATE OF DEATH Month <u>JAN.</u> Day <u>7</u> Year <u>1959</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 19 1980</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>SALEM, MO.</u> ^c	
13. FATHER'S NAME <u>WILLIAM P. ELMER</u>			14. MOTHER'S MAIDEN NAME <u>SARAH WAGNER</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 Address <u>ROBERT L. MUSGRAVES, CRYSTAL CITY, 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>Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart Disease.</u>		<u>5 yrs plus</u>
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II(a) <u>Hyper-trophic arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
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 _____ 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 October 6, 1945 to January 7, 1959 and last saw ^{her} ~~him~~ alive on Jan. 7, 1959
Death occurred at 8:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John F. Rutledge M.D.</u>	22b. ADDRESS <u>Crystal City, Mo.</u>	22c. DATE SIGNED <u>1-9-59</u>
--	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-11-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR GROVE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>SALEM, MO.</u>
---	-----------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS <u>James P. Cady - Crystal City, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-10-59</u>	26. REGISTRAR'S SIGNATURE <u>John A. Rogers</u>
--	--	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

06

Vertical text on the left margin.

STATE OF IOWA
JAN 13 1939

STATEMENT BY LICENSED EMBALMER

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

Student.....
Signature of Student Embalmer

Signed *James Richard Cady*
Licensed Embalmer No. 4

P. O. Address *Crystal*

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