

REGISTRATION DISTRICT NO. 9 AUG 19 1940

Primary Registration District No. 4286

Registrar's No. 8

1. PLACE OF DEATH

(a) County Lewis
(b) City or town Canon
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 20 years
years, months or days

8. (a) PRINT FULL NAME John Hartnett Husgron

8. (b) If veteran, name, war None 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 29 1873
(Month) (Day) (Year)

8. AGE: Years 67 Months 0 Days 12 If less than one day hr. _____ min. _____

9. Birthplace Canon Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name William H Husgron

13. Birthplace Waverly Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Lucy Ann Wolf

15. Birthplace Lewis Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature William Husgron

(b) Address Wheeler Mo

17. (a) Burial (b) Date thereof July 12 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Canon Mo

18. (a) Signature of funeral director H. S. Kelly

(b) Address Canon Mo

19. (a) July-29-1940 (b) P. W. Jennings
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clartt

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10th
year 1940 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from July 5
5th, 1940, to July 10 40, 1940
that I last saw him alive on July 9, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death acute indigestion Duration 5 hrs.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(c) Where did injury occur? no
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

997 (Specify type of place) While at work? (e) Means of injury _____

23. Signature P. W. Jennings (M. D. or other)

Address Canon Mo Date signed 7/12/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importa

118c

RECEIVED

District Health Officer No. 10

District File Number 8-40-1636

Date Filed AUG 15 1940

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

W. D. Kelly

Registered Apprentice No.

working under my personal supervision.

Signed

W. D. Kelly

Licensed Embalmer No.

1933

P. O. Address

Centre M

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25-602**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **477**

Primary Registration District No. **4286**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Lewis**
(b) City or town **Canon**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, month or days)

3. (a) PRINT FULL NAME

John Hartnett Musgrove

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **67** Months **0** Days **12** If less than one day _____ min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

20. MEDICAL CERTIFICATION

20. DATE OF DEATH Month **July** day **10** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **acute indigestion**
Due to **Valvular disease of heart**
Due to _____

Other conditions (Include pregnancy within 3 months of death) **92W**

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury _____

23. Signature **P.W. Jennings** (M. D. or other) _____
Address **Canon Mo.** Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

