

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 important.

NOV 16 1940 791
Registration District No.

Primary Registration District No. 1003

8297
Registrar's No.

1. PLACE OF DEATH:
(a) County _____
(b) City or town ST. LOUIS
(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME NETTIE MUSGRAVE
3. (b) If veteran, name war. No.
3. (c) Social Security No. None

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

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

7. Birth date of deceased Dec. 4 1871
(Month) (Day) (Year)

8. AGE: Years 68 Months 10 Days 0
If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name William Shepherd

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

14. Maiden name LAURA JUDY

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

16. (a) Informant's own signature Mrs. Helen Mitchell

(b) Address Bridgeport, Ill.

17. (a) Removal (b) Date thereof 10-4-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lawrenceville, Ill.

18. (a) Signature of funeral director Albert H. Honpe

(b) Address 4700 Washington Ave.

19. (a) OCT 5 1940 (b) J. B. Bradley
(Date received local registrar) (Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State ILLINOIS (b) County _____
(c) City or town MT. CARMEL NR
(If outside city or town limits, write "RURAL.")
(d) Street No. 1020 NORTH POPLAR
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 4
year 1940 hour 9 minute 5 A. M.

21. I hereby certify that I attended the deceased from SEPTEMBER 14, 1940, to OCTOBER 4, 1940;
that I last saw her alive on OCTOBER 4, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease
Cardiac decompensation

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

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)
(a) Means of injury _____

23. Signature J. B. Bradley (M. D. or other) _____

Address BARNES HOSPITAL Date signed 10/1/40

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.