No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 24 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38475
9923

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH:
(a) County
(b) City or town City St. Louis.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Infirmary Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7-30-1943 / 11-14-1948 (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Aged
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 5149 CATES AVE
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Joel Mustain.
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife GRACE 6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased NOV. (Month) 16th (Day) 1877 (Year)

8. AGE: Years 70 Months 11 Days 28 If less than one day hr. min.

9. Birthplace ~~Retired~~ Missouri (City, town, or county) (State or foreign country)
10. Usual occupation Laborer (Retired)
11. Industry or business

MOTHER FATHER
12. Name THOMAS MUSTAIN
13. Birthplace VIRGINIA (City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace VIRGINIA. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Grace Mustain
(b) Address 5149 Cates Ave.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11/17/48 (Month) (Day) (Year)
(c) Place: burial or cremation MEMORIAL PK CEM
18. (a) Signature of funeral director Tony Mullen
(b) Address 5165 Delmar Blvd.
19. (a) NOV 16 1948 (Date received local registrar) (b) J. B. Lasater (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11- day 14- year 1948 hour 8 minute 50p. M.
21. I hereby certify that I attended the deceased from July 7 1948, 19 to 11-14- 1948; that I last saw him alive on 11-14- 1948; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Emphysema
Due to Chronic Bronchial asthma
Due to
Other conditions Arteriosclerotic Heart Disease (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy refused

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Clifford L. Krag M.D. (M. D. or other)
Address 5600 Arsenal St. St. Louis Date signed Nov 15 1948

Jefferson City Printing Co. (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 _____ Registered Apprentice No. _____, working under my personal supervision.

Signed F. G. Farris

Licensed Embalmer No. 3384

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 this body is not embalmed, fact should be so stated above.