

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32204**

FILED NOV 7 1955

BIRTH NO. _____ REG. DIST. NO. **38** PRIMARY REG. DIST. NO. **3006** Registrar's No. **299**

1. PLACE OF DEATH a. COUNTY BOONE			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY LINN		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN COLUMBIA		c. LENGTH OF STAY (in this place) 16 DAYS	c. CITY OR TOWN WHEELING		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION ELLIS FISCHL STATE CANCER HOSPITAL			e. STREET ADDRESS (If rural, give location) R.F.D. 2581		

3. NAME OF DECEASED (Type or Print) a. (First) MAUDE b. (Middle) SOPHIA c. (Last) MUSGROVE			4. DATE OF DEATH (Month) (Day) (Year) NOV. 7 1955		
--	--	--	---	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH NOV. 17, 1877	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months 11 Days 21	IF UNDER 4 HRS. Hour 21 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME JOHN W. MOORE		13b. MOTHER'S MAIDEN NAME HONOR LUCIAL WOLFE		14. NAME OF HUSBAND OR WIFE UNKNOWN (DECEASED)	
--	--	--	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS HOSPITAL RECORDS			
---	--	--	--	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH Unknown
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 4200H				
	DUE TO (c) Carcinoma of left breast, locally advanced				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 8 mo
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **10-17, 1955**, to **11-2, 1955**, that I last saw the deceased alive on **11-2, 1955**, and that death occurred at **1300 AM** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Richard E. Johnson, M.D.		23b. ADDRESS Columbia, Mo		23c. DATE SIGNED 11-2-55	
--	--	----------------------------------	--	---------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Nov 2 1955	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Laredo Mo		
---	--------------------------------	------------------------------------	---	--	--

DATE REC'D BY LOCAL REG. Nov. 2 1955	REGISTRAR'S SIGNATURE Mrs. R.E. Palmer	25. FUNERAL DIRECTOR'S SIGNATURE Lynard Sprinkle	ADDRESS Columbia Mo		
--	--	--	-------------------------------	--	--

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

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 *Lyman H. Spunkle*

Licensed Embalmer No. *401*

P. O. Address *Calumet*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.