

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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

56

FEB 18 1928

1. PLACE OF DEATH

County Andrew
Township Salisbury
City Waver

Registration District No. 26
Primary Registration District No. 3872
(No. 413 West Union)

File No. _____
Registered No. 2
St. 2 Ward

2. FULL NAME

(a) Residence. No. _____ St. 2 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Dec-2-1876

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

50

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Brown Co

(STATE OR COUNTRY)

MO

10. NAME OF FATHER

James C. Ashbury

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Brown Co

(STATE OR COUNTRY)

MO

12. MAIDEN NAME OF MOTHER

Russell Robert

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Brown Co

(STATE OR COUNTRY)

MO

14.

INFORMANT

(Address)

Anna B. Landrum
Mexico MO

15.

FILED

Jan 4th 1928

Ira S. Milligan
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Jan 3 1928

17.

I HEREBY CERTIFY That I attended deceased from Dec-24, 1927, to Jan 3, 1928

that I last saw him alive on Jan 3, 1928, and that death occurred, on the date stated above, at 11:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic R. Pneumonia
of Right Lung

108 D
106 A

CONTRIBUTORY (SECONDARY)

Cold

18. WHERE WAS DISEASE CONTRIBUTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) R. H. Fisher, M. D.

, 19 (Address) Mexico MO

*State the DISEASE CAUSING DEATH, or if death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Buried to Cem MO 5-1928

20. UNDERTAKER

ADDRESS

H. A. Brechtel Mexico MO

AGE OF DE
B—Every

in terms of the
information and de

Company
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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Atchison

Registration District No. 26

File No. _____

Township _____

Primary Registration District No. 3002

Registered No. 2

City Mexico (No. _____ St. _____ Ward _____)

2. FULL NAME

Aquilla Johnes Asbury

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Dec 2 - 1876

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, _____ hrs.
or _____ min.

X 51 X 1 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

15.

Jan 4th 28 Ira S. Milligan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Jan 3 1928

17.

I HEREBY CERTIFY, That I attended deceased from _____

_____ 19____, to _____ 19____,
that I last saw him _____ after on _____ 19____, and that
death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

19

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