

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

Do not use this space.

6096

**1. PLACE OF DEATH**

County Gentry  
Township \_\_\_\_\_  
City Albany (No. \_\_\_\_\_)

Registration District No. 309  
Primary Registration District No. 4185

File No. \_\_\_\_\_  
Registered No. 14  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Mary Ann Asher

(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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 11 - 1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Gentry Co. Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER James McQuinn

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ky.  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Juliah Ball

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ky.  
(STATE OR COUNTRY)

14. INFORMANT St. D. Asher  
(Address) Albany Mo.

15. Mar 6 29 W. T. Moshier  
FILED REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 28 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb. 26<sup>th</sup>, 1929, to Feb. 28<sup>th</sup>, 1929, that I last saw him alive on Feb. 28<sup>th</sup>, 1929, and that death occurred, on the date stated above, at 9 p.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

1. Cerebral Hemorrhage  
11. Hypostatic Pneumonia  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)  
(duration) yrs. mos. ds.

**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) Wm. S. Campbell, M. D.  
3/6, 1929 (Address) Albany Mo.

\*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

Stent Cemetery March 30 29  
20. UNDERTAKER ADDRESS  
A. T. Base Albany

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
ALBANY, MO.  
MAR 22 1929  
CAUSE OF DEATH: 1. Cerebral Hemorrhage 2. Hypostatic Pneumonia

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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 Gentry  
Township \_\_\_\_\_  
City Albany (No. \_\_\_\_\_)

Registration District No. 309  
Primary Registration District No. 4185-

File No. \_\_\_\_\_  
Registered No. 14  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 11 - 1848

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
80 4 17

**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) \_\_\_\_\_

PARENTS

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.

11/5/24 W. J. Martin  
REGISTERAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) FEB 28 1929

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral Hemorrhage  
Complicated Pneumonia  
Baccho Pneumonia  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRAICTED

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

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. OCCUPATION should be stated. STATEMENT OF OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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