

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

Do not use this space.

21318

1. PLACE OF DEATH

County Howell
Township West Plains, Mo.
City West Plains, Mo.

Registration District No. 384
Primary Registration District No. 4227

File No. 60
Registered No. _____
St. _____ Ward) _____

2. FULL NAME

Clarence 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

ma

4. COLOR OR RACE

wht

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

child

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

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

Oct 14 - 1911

7. AGE

YEARS

MONTHS

DAYS

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

3

8

4

8. OCCUPATION OF DECEASED

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

Child

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

West Plains, Mo.

(STATE OR COUNTRY)

10. NAME OF FATHER

J. B. Asbury

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Missouri

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Lana Belle Bell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Arkansas

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

J. B. Asbury
West Plains, Mo.

15.

FILED

6-18-29 O. A. Neunrich

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

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

6/8 - 1929

17.

I HEREBY CERTIFY That I attended deceased from June 4th, 1929 to June 7th, 1929 that I last saw him alive on June 7th, 1929, and that death occurred, on the date stated above, at 2:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia, double.

107A

(duration) yrs. mos. 10 da.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? NO. DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical

(Signed) A. P. H. H. H. H., M. D.

6/14, 1929 (Address) West Plains, 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

Lumpston

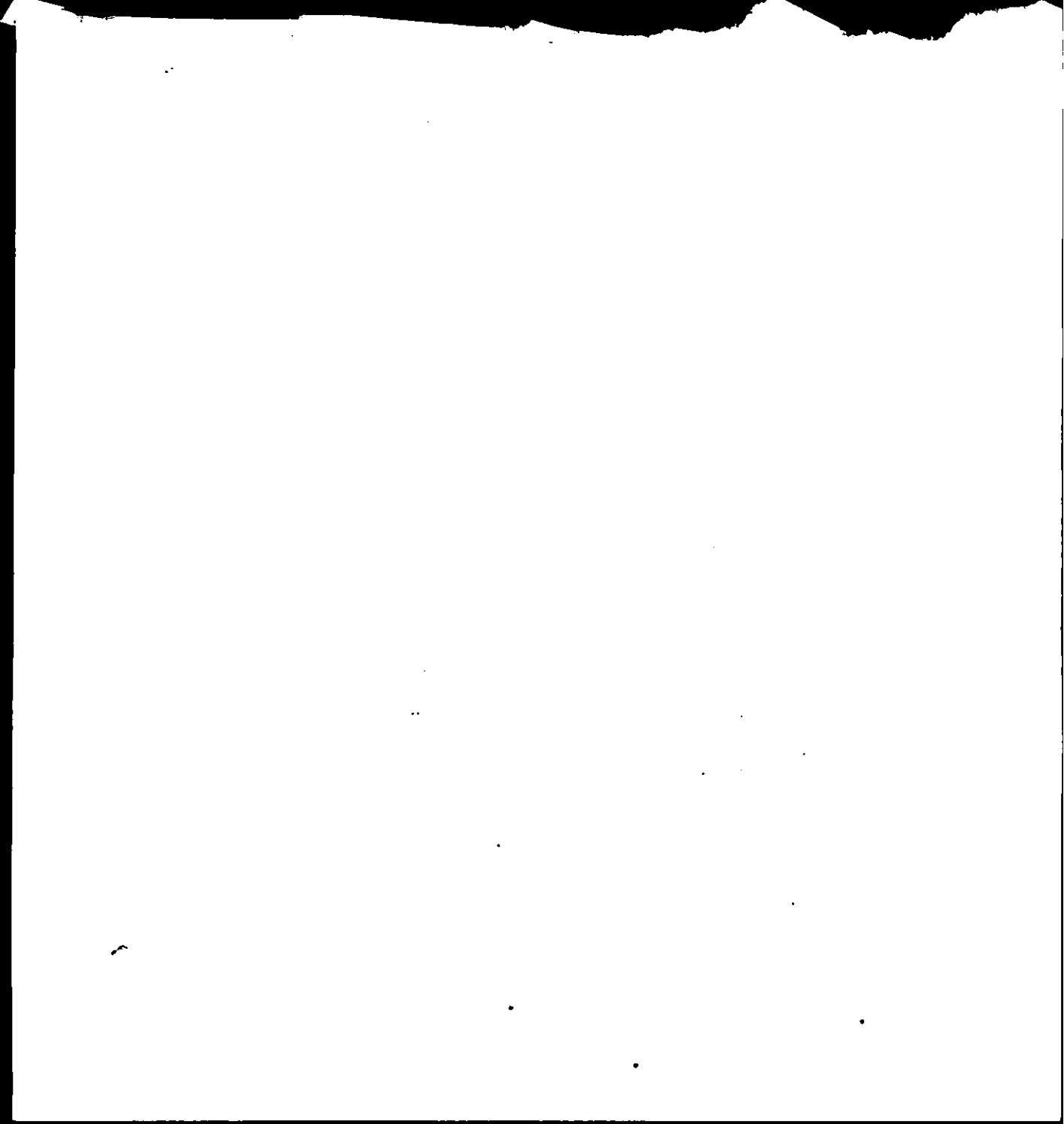
6/9 - 1929

20. UNDERTAKER

ADDRESS

McFarland's

West Plains, Mo.



**ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.**

1. PLACE OF DEATH

County Bowling Registration District No. 584 File No. 60
Township West Plain Primary Registration District No. 4227 Registered No. _____
City West Plain No. _____ St. _____ Ward _____

2. FULL NAME

(a) Residence. No.			St.	Ward.	(If nonresident, give city or town and State)		
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
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5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

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

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

1 (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.

FILE 6-18 19 79 OK Heinrich

REGISTRATION

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6 - 8 - 1943

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1. Whooping Cough
 (duration) yrs. mos. ds.

~~CONTRIBUTORY~~
~~(SECONDARY)~~

.. (duration) yrs. mos. da

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
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19

REGISTRATION SHALL RECEIVE A CERTIFICATE OF REGISTRATION UPON RECEIVING THE FEE AS PRESCRIBED BY LAW. K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain language, so that it may be properly classified. Exact statement of OCCUPATION is very important in terms.

S-21318