49

SEP 25 1929

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

Do not use this space.

28140

1. PLACE OF DEATH
County Jasper
Township Sarcoxie
City Sarcoxie (No. ..... St. ..... Ward)

Registration District No. 416
Primary Registration District No. ~~4448~~ 5571a

File No. .....
Registered No. 18

2. FULL NAME Joseph C. Ash
(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 28 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 1 - 1846

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
82	8	5	

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) Farm Duty's
(c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa

PARENTS
10. NAME OF FATHER Samuel Ash
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Scotland

14. INFORMANT Emma [illegible]
(Address) Sarcoxie, Mo.

15. FILED Aug 6, 1929 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 5 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 3, 1929, to Aug 5, 1929, that I last saw him alive on Aug 5, 1929, and that death occurred, on the date stated above, at 10:00 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Angina Pectoris
94 [illegible]
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 89
..... (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) J. W. Boyd, M. D.
8/5, 1929 (Address) Sarcoxie 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 Pierce City Cemt
DATE OF BURIAL Aug 8 1929

20. UNDERTAKER Sarcoxie Und Co
ADDRESS Sarcoxie Mo

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.