

APR 28 1930

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

Do not use this space.

8428

1. PLACE OF DEATH

County Clay
Township Franklin
City (No. _____) _____ St. _____ Ward _____

Registration District No. 329
Primary Registration District No. 5456

File No. _____
Registered No. 5

2. FULL NAME

Rosa Amanda Ashcroft
(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

2. SEX

Female

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

wife of Dove Ashcroft

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

July 23 1878

7. AGE

YEARS

MONTHS

DAYS

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

52

1

18

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)

Murphy County Mo

(STATE OR COUNTRY)

Mo

PARENTS

10. NAME OF FATHER

James Kerriford

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Murphy Co Mo

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Annie Wilcox

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Murphy Co Mo

(STATE OR COUNTRY)

14.

INFORMANT (Address)

Dove Ashcroft
Spickard Mo

15.

FILED Mo. Co. 19. 30.

E W Ewing

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 14 1930

17. I HEREBY CERTIFY, That I attended deceased from 7 Mar 1930, to 14 Mar 1930 that I last saw him alive on Mar 13 1930, and that death occurred, on the date stated above, at 6:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemorrhage of Brain
24h (duration) yrs. mos. 2h
CONTRIBUTORY Malaria fever
(SECONDARY) (duration) yrs. mos. 7 ds.

18. WHERE WAS DISEASE CONTRIBUTED?

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) A. W. Taylor, M. D.

Mar 18 1930 (Address) Spickard 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

Mill Grove Wrens Mo 3/16 1930

20. UNDERTAKER

ADDRESS

Chas E Schaefer Spickard 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.

