

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

Do not use this space.

19635

1. PLACE OF DEATH

County Jackson
Township Kear
City K.C. Mo. (No. 525 Indiana

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 2636
St. _____ Ward _____

2. FULL NAME

Bonnie Kles Ashton
(a) Residence No. 525 Indiana St. 9 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) _____

Fe White Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July-18-1903

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
26 11 7

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Manager of
(b) General nature of industry, business, or establishment in which employed (or employed by) Orchester Import
(c) Name of employer See

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Lima Ohio

PARENTS

10. NAME OF FATHER J.L. Ashton

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

12. MAIDEN NAME OF MOTHER Eloa A. Mason

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

14. INFORMANT J.L. Ashton
(Address) 525 Indiana

15. FILED 6/26 1930 M.M. Crowe REGISTRAR
assr

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June-25-1930

17. I HEREBY CERTIFY, That I attended deceased from April 6th, 1930, to June 25th, 1930 that I last saw her alive on June 24th, 1930, and that death occurred, on the date stated above, at 3:30 A.M. m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Embolism of left middle meningeal artery

920 (duration) _____ yrs. _____ mos. 3 ds.
CONTRIBUTORY malignant Endocarditis (SECONDARY)
(duration) _____ yrs. 3 mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS Clinical + Laboratory
(Signed) Samuel Voegelie M.D.

6/25, 1930 (Address) 604 Commerce Bldg

*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 Mt. Moriah DATE OF BURIAL June 27 1930

20. UNDERTAKER Mrs. C.L. Forster ADDRESS K.C. Mo.

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.

604

3236 Roberts Be-5803

4-43 minutes 6:30 P.M.

**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..... Registration District No. 399 File No.
 Township..... Primary Registration District No. 1002 Registered No. 2636
 City K. City (Name)..... St. Ward)

2. FULL NAME

Bonnie Kler Ashton

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

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.

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)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Embolism of left middle meningeal artery

CONTRIBUTORY (SECONDARY) Myocarditis Endocarditis

18. WHERE DID DISEASE OR INJURY ORIGINATE? (duration) yrs. mos. da.

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHO FIRST CONFIRMED DIAGNOSIS?.....

(Signed) Samuel Voegelius, M. D.

....., 1930 (Address) August 119-1930

*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.

14. INFORMANT (Address)

15. FILED 6/26 30 M. M. Grobe REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

N. E. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY PLACE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRATION FEE SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY
NON RESPECTABLE
Embolism of left middle meningeal artery
Myocarditis Endocarditis
Samuel Voegelius, M. D.
August 119-1930

S-19635

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