

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

Do not use this space.

36217

**1. PLACE OF DEATH**  
 County Jackson Registration District No. \_\_\_\_\_  
 Township Jaco Primary Registration District No. \_\_\_\_\_  
 City K.C. Mo. (No. St. Mary's Hospital St. \_\_\_\_\_ Ward) \_\_\_\_\_  
**2. FULL NAME** Erma Ashton  
 (a) Residence No. 4142 Leavitt (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** 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** Allen Ashton  
**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Sept. 8-1906  
**7. AGE**  
 YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
24 2 5

**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work. Housewife  
 (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)** Kansas

**PARENTS**  
**10. NAME OF FATHER** John A. Henderson  
**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** Tenn  
**12. MAIDEN NAME OF MOTHER** Clara Ester  
**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** Michigan

**14. INFORMANT** Dean Henderson  
 (Address) 139 No. Chelsea

**15. FILED** 11-10-30 M. McCreary  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Nov-13-1930  
**17. I HEREBY CERTIFY, THAT I attended deceased from** 6/11 11-13 30  
 that last saw her alive on 11-13 30, and that death occurred, on the date stated above, at 9:15 am m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
Tuberculosis, military lungs  
adneps. pleen. meningeo  
3017 (duration) 15 yrs. 3 mos. 3 ds.  
**CONTRIBUTORY (SECONDARY)** Tuberculosis Left Pleura. (duration) 3 yrs. 3 mos. 3 ds.

**18. WHERE WAS DISEASE CONTRACTED** 301 So Lawn  
 IF NOT A PLACE OF RESIDENCE K.C. Mo  
**19. DID AN OPERATION PRECEDE DEATH?** No DATE OF \_\_\_\_\_  
**20. WAS THERE AN AUTOPSY?** No  
**21. WHAT TEST CONFIRMED DIAGNOSIS?** M. J. Oakes  
 (Signed) 1/14 19 30 (Address) 1034 Realt Bldg M.D.

\*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** Calvary **DATE OF BURIAL** Nov-17-1930

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

N. E.—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.

Rialto - Vi - 2813  
701 E - 45 12 - 2460