

DEC 22 1930

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

Do not use this space.
36770

1. PLACE OF DEATH

County Madison
Township Castor
City (No.)

Registration District No. 630
Primary Registration District No. 5727

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

2. FULL NAME

Burland Aslinger

(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

3. SEX

m

4. COLOR OR RACE

w

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

single

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

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

Feb 20 1904

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>26</u>	<u>9</u>	<u>24</u>	

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) _____

(c) Name of employer _____

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

Marquand Mo.

PARENTS

10. NAME OF FATHER

Anderson Aslinger

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

Marquand Mo.

12. MAIDEN NAME OF MOTHER

Nester McComick

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

Rollinger, Mo.

14. INFORMANT (Address)

Anderson Aslinger Marquand Mo.

15. FILE NO.

MO 2019 20 C U. S. DEPT. OF HEALTH REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Nov 14 1930

17.

I HEREBY CERTIFY, That I attended deceased from Nov 1 1930 to Nov 13 1930, that I last saw him alive on Nov 13 1930, and that death occurred, on the date stated above, at 6:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Typhoid fever

(duration) yrs. mos. ds. 2
CONTRIBUTORY (SECONDARY) Hemorrhage from bowels (duration) yrs. mos. ds. 6

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) W. Harry Barron M. D.

Nov 15, 1930 (Address) Fredricks town 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

Rhodes Chapel - Medicine Co. Mo.

Nov. 15 1930

20. UNDERTAKER

ADDRESS

none

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. Do not use this space.

