

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

Do not use this space.

9136

File No. \_\_\_\_\_  
Registered No. 19  
St. \_\_\_\_\_ Ward \_\_\_\_\_

1. PLACE OF DEATH  
38 County Gentry Registration District No. 309  
1 Township \_\_\_\_\_ Primary Registration District No. 4185-  
2 City Albany (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

2. FULL NAME Leslie Asher  
(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**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 20 1933

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

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 1922, to Mar 20 1933, that I last saw him alive on Mar 10 1933, and that death occurred, on the date stated above, at 7 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 19-1933

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>0</u>	<u>0</u>	<u>1</u>	

Brainstem Palsy  
159 (duration) yrs. mos. 1 ds.

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work none  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

CONTRIBUTORY (SECONDARY) 159 (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

10. NAME OF FATHER A.A. Asher

IF NOT AT PLACE OF DEATH \_\_\_\_\_

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

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

12. MAIDEN NAME OF MOTHER Elizabeth Chetum  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Albany Mo.  
(STATE OR COUNTRY)

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) J.N. Barger, 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.  
4/3 1933 (Address) Albany Mo.

14. INFORMANT A.A. Asher  
(Address) Albany Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

15. Mar 7 33 H.S. Dyer  
REGISTRAR

Grandview  
20. UNDERTAKER A. J. Bare Albany

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.

APR 27 1933

