

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

17241

**1. PLACE OF DEATH**

County Knox  
Township Highland  
City Loca Mac Ashby

Registration District No. 443  
Primary Registration District No. 5600K

File No. 1-1934  
Registered No. 3  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(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) Jan 10, 1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
62 4 19

**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) Knox Co. Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER Thomas M. Ashby  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ind  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER May E. King  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ind  
(STATE OR COUNTRY)

14. INFORMANT Mrs. Elbert Kester  
(Address) Grasheer, Mo.

15. FILED 6/2 1934 Geo B. Early Jr. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 29 1934

17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1934, to May 29 1934  
that I last saw him alive on May 28 1934 and that death occurred, on the date stated above, at 2.10 p.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Carcinoma of right lung  
secondary to breast amputation  
in 1923  
150 (duration) 12 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Carcinoma of uterus, lumbar spine & sacrum (duration) 1 yrs. 6 mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

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

1 DID AN OPERATION PRECEDE DEATH? DATE OF 1923

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

WHAT TEST CONFIRMED DIAGNOSIS? Biochemistry  
(Signed) J. A. Schwartz D.O.  
, 19 (Address) Highland 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 2000 N. Kernalah DATE OF BURIAL 5/30 1934

20. URBERTAKER J. B. Early Jr. ADDRESS Highland Mo

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

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.

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

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County.....  
Township.....  
City..... (No. ....) .....

Registration District No. ....

Primary Registration District No. ....

File No. ....

Registered No. ....

St. .... Ward

## 2. FULL NAME

(a) Residence. No. ....  
(Usual place of abode)

St. .... Ward

Length of residence in city or town where death occurred yrs. .... mos. ....

(If nonresident, give city or town and State)

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) .....

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)

14. INFORMANT (Address) .....

15. FILED..... 19..... REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) ..... 19.....

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED ..... (duration) ..... yrs. .... mos. .... ds. ....

IF NOT AT PLACE OF DEATH

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

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) ..... M. D. ....  
..... 19 (Address)

\*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

20. UNDERTAKER

ADDRESS

19