

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

DEC 0 JUN 19 1939

17970

Do not use this space.

1. PLACE OF DEATH

(a) County Bates Registration District No. 47
 (b) Township Deer Creek Primary Registration District No. 5070 Registered No. 12
 (c) City Near Adrian (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Elias Albert Askew
 (a) Residence, No. _____ St. ☐ (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frankie Elizabeth Askew
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr-3-1853
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
86 1 18
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russelville Ky
 13. NAME Robert Askew
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russelville Ky
 15. MAIDEN NAME Lucille Leary
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russelville Ky
 17. INFORMANT (ADDRESS) Sheldon Askew
 18. BURIAL, CREMATION, OR REMOVAL PLACE Cement Hill DATE May 22 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Leath & Dix
Adrian
 20. FILED June 1, 1939 Ethel C. Stephens
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 21 1939
 22. I HEREBY CERTIFY, That I attended deceased from May 21 1939 to May 21 1939
 I last saw him alive on May 21 1939 Death is said to have occurred on the date stated above, at 9:30 A.M.
 The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage
 Date of onset
5 2 1
 Other contributory causes of importance:
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) E. E. Robinson, M. D.
Adrian, Mo.
50 (Address)

RECEIVED
District Health Officer No. 71
District File Number 7-39-846
Date Filed 6-2-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

This body was Not Embalmed

Registered Apprentice No., working under my personal supervision.

Signed

Licensed Embalmer No. 3650

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.