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.

REC'D SEP 20 1939

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

29221
Do not use this space.

1. PLACE OF DEATH
(a) County Grundy 1 Registration District No. 3292
(b) Township Marion Primary Registration District No. 5454 A Registered No.
or
(c) City (d) Street No. St.
(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 260 LEONA FRANCES ASHER
(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 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 S. S. Asher
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 29 - 1867
7. AGE YEARS 71 MONTHS 8 DAYS 11 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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) Grundy Co Mo

FATHER
13. NAME Daniel Holloway
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

MOTHER
15. MAIDEN NAME Julia Tindall
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Madison Co Ill

17. INFORMANT (ADDRESS) S. S. Asher Dimeas Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Rural Dale DATE Aug 2 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. J. Robertson Laredo Mo
20. FILED Aug 5 1939 J. C. Humphreys Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 1 1939
22. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Aug 1, 1939, to ....., 19....
I last saw h... alive on Aug 1, 1939 Death is said to have occurred on the date stated above, at 2 Am.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of Lung	June 1939

Other contributory causes of importance:
Carcinoma of Lung

Name of operation Date of 1936
What test confirmed diagnosis? Was there an autopsy? No

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? No
If so, specify
(Signed) J. Mann M.D.
(Address) Trenton Mo

(Licensed Embalmer's Statement on Reverse Side)

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, ~~or by~~.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....E. J. Robertson.....

Licensed Embalmer No.....2465.....

P. O. Address.....Jaredo, Miss.....

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

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