WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
REC'D OCT 18 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31602

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 3700

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 6837 Walrond (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ______ In this community ______ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Jackson
(c) City or town: Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 6839 Walrond (If rural, give location)
(e) If foreign born, how long in U. S. A.? ______ years.

3. (a) PRINT FULL NAME: James Ashby
3. (b) If veteran, name war: no
3. (c) Social Security No.: no
4. Sex: M
5. Color or race: W.
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Elizabeth Ashby
6. (c) Age of husband or wife if alive ______ years
7. Birth date of deceased: Sept. 9 1860 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day hr. min.
74	0	11	

9. Birthplace: ______ (City, town, or county) Virginia (State or foreign country)
10. Usual occupation: Stone Mason
11. Industry or business: ______
FATHER 12. Name: Jerry Ashby
13. Birthplace: ______ (City, town, or county) Virginia (State or foreign country)
MOTHER 14. Maiden name: " "
15. Birthplace: " " (City, town, or county) (State or foreign country)
16. (a) Informant's own signature: Mrs Cassie Hinds
(b) Address: 6724 Ashland
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-22-39 (Month) (Day) (Year)
(c) Place: burial or cremation: Forest Hill
18. (a) Signature of funeral director: Bentley Mortuary
(b) Address: 5811 Troost Ave
19. (a) Sept 22 1939 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20 year 1939 hour ______ minute ______ M.

21. I hereby certify that I attended the deceased from June, 1934 to Sept 20, 1939 that I last saw him alive on Sept 19, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerotic Heart Disease; Senile
Due to: Emphysema
Due to: 95 12

Duration: ______

Other conditions (Include pregnancy within 3 months of death): ______

Major findings: Of operations: ______ Of autopsy: ______

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ______
(b) Date of occurrence ______
(c) Where did injury occur? ______ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ______ (Specify type of place)
While at work? ______ (e) Means of injury ______

23. Signature: P. H. De Maria M.D. (M.D. or other)
Address: Supt K C Gen Hosp ... Date signed 9-21-39

(Licensed Embalmer's Statement on Reverse Side)

I X19511

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, GUY E. BUFFINGTON

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

working under my personal supervision.

Signed Guy E Buffington

Licensed Embalmer No. 2756

P. O. Address K C Mo

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

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