

Dr. G. Martin

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3104

State File No. _____

FEB 20 1940

Registration District No. *567*

Primary Registration District No. *4334*

Registrar's No. *7*

1. PLACE OF DEATH: *Mississippi*

(a) County *Mississippi*

(b) City or town *East Prairie, Mo.*

(c) Name of hospital or institution: _____

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community *10 mo.* _____ (Specify whether)

years, months or days _____

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Mississippi*

(c) City or town *East Prairie, Mo.*

(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME *MATTIE ASHLEY*

3. (b) If veteran, name war *L*

3. (c) Social Security No. _____

4. Sex *Fem* 5. Color or race *W*

6. (a) Single, widowed, married, divorced *Married*

6. (b) Name of husband or wife *Claud Ashley*

6. (c) Age of husband or wife if alive *56* years

7. Birth date of deceased *Oct 10 1905*

(Month) (Day) (Year)

8. AGE: Years *37* ✓ Months *3* Days *21* hr. _____ min.

If less than one day

9. Birthplace *Penn.*

(City, town, or county) (State or foreign country)

10. Usual occupation *Keeping house*

11. Industry or business _____

MOTHER FATHER

12. Name *Unknown*

13. Birthplace *Unknown*

(City, town, or county) (State or foreign country)

14. Maiden name *Unknown*

15. Birthplace *Unknown*

(City, town, or county) (State or foreign country)

16. (a) Informant's own signature *Claud Ashley*

(b) Address *East Prairie, Mo.*

17. (a) *Burial* (b) Date thereof *Feb 1-40*

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *W. O. W.*

18. (a) Signature of funeral director *Frank J. Shelly*

(b) Address *East Prairie, Mo.*

19. (a) *Shelly* (b) *Martin*

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Jan* day *31*

year _____ hour *2* minute *40* M.

21. I hereby certify that I attended the deceased from *Jan. 31*

19*40* to *Jan 31*, 19*40*

that I last saw her alive on *Jan. 31*, 19*40*

and that death occurred on the date and hour stated above.

Immediate cause of death *Pneumonia*

Due to *Flu*

Due to *11a*

Other conditions *Pregnancy 6 months*

(Include pregnancy within 3 months of death)

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?

While at work? _____ (Specify type of place)

23. Signature *A. J. Martin* (M. D. or other)

Address *East Prairie* Date signed *2/6*

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.

RECEIVED.

District Health Officer

District File Number *214*

Date Filed *2/14/14*

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 *James M. Shelby*

Licensed Embalmer No. *2726*

P. O. Address *East Prairie, Mo.*

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

3104
Do not use this space.

1. PLACE OF DEATH

(a) County Mississippi Registration District No. 367
(b) Township East Prairie Primary Registration District No. 4334 Registered No. 7
(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

Mattie Ashley
(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write court or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 10 1903

7. AGE YEARS 36 MONTHS 3 DAYS 21 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19.....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Feb 1 1940 Mrs. D. M. Hodge Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 31 1940

22. I HEREBY CERTIFY, That I attended deceased from 19..... to..... 19.....

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Date of onset

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) A. J. Martin, M. D.
(Address) East Prairie

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
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.

SUPPLEMENTARY

S-3104