

REC'D FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **4115**

Registration District No. **772**

Primary Registration District No. **446.3**

Registrar's No. **10122**

1. PLACE OF DEATH:

(a) County **St. Francois**
(b) City or town **Effie Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Francis**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1**
(Specify whether
In this community
years, months or days)

8. (a) PRINT FULL NAME **Martha Cordella Asher**

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **White** 8. (a) Single, widowed, married, divorced **2**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Jan 4 1864**
(Month) (Day) (Year)

8. AGE: Years **77** Months _____ Days **22** If less than one day hr. _____ min. _____

9. Birthplace _____ (City, town, or county) **Mo.** (State or foreign country)

10. Usual occupation **House work**

11. Industry or business _____

12. Name **James Asher**

13. Birthplace **Virginia** (City, town, or county) (State or foreign country)

14. Maiden name **Edith Ormsby**

15. Birthplace **Tenn.** (City, town, or county) (State or foreign country)

16. (a) Informant **Luther Asher**

(b) Address **Elvis R R**

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation **0.007 Cemetery**

18. (a) Signature of funeral director **Lo adwell Row**

(b) Address _____
19. (a) **1-28-41** (b) **OB** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St. Francois 94**
(c) City or town **Effie** (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **0**
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **26**
year **1941** hour **one** minute **30** A.M.

21. I hereby certify that I attended the deceased from **1-7-41**
19____ to **1-26** 19**41**
that I last saw him alive on **1-25-41** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

Due to **Influenza & acute Bronchitis** 2 Weeks

Due to **arterial sclerosis, chronic nephritis & chronic myocarditis** several years

Other condition **arterial hypertension**
(Include pregnancy within 3 months of death)

Major findings: Of operations **L**

Of autopsy **L**

22. If death was due to external causes, fill in the following: **L**

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence **L**

(c) Where did injury occur? **L** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **L**

While at work? **L** (Specify type of place) (e) Means of injury **L**

23. Signature **Paul J. Jones M.D.** (M. D. or other) **D**
Address **Flat Room, Mo** Date signed **1-27-41**

Duration
PHYSICIAN
Underlines the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Licensed Embalmer No.....

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.