

U. S. No. 2  
-1-4-41  
15-17-39  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **6289**  
Registrar's No. **24**

Registration District No. **7000 MAR 20 1943**

Primary Registration District No. **4194**

1. PLACE OF DEATH:  
(a) County **Gentry**  
(b) City or town **Albany**  
(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 **All her life**  
In this community **All her life**  
years, months or days

3. (a) PRINT FULL NAME **Elizabeth Georgia Asher**  
3. (b) If veteran, name war **No.** 3. (c) Social Security No. **No.**

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**  
6. (b) Name of husband or wife **Alford A. Asher** 6. (c) Age of husband or wife if alive **38** years  
7. Birth date of deceased **June 12 1907**  
(Month) (Day) (Year)

8. AGE: Years **35** Months **8** Days **18** If less than one day **hr. min.**

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

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER { 12. Name **Chas. Cheatham**  
13. Birthplace **Unknown Unknown**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Bianche Stagner**  
15. Birthplace **Unknown Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Alford Asher**  
(b) Address **Albany, Mo.**

17. (a) **Burial** (b) Date thereof **3/4/43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Grandview**

18. (a) Signature of funeral director **W. H. ...**  
(b) Address **Albany, Mo.**

19. (a) **March 4-43** (b) **James W. ...**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **38**  
(a) State **Missouri** (b) County **Gentry**  
(c) City or town **Albany**  
(If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? **No.** (Yes or No)  
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **2**  
year **1943** hour **6** minute **40P.** M.  
21. I hereby certify that I attended the deceased from **April 6-42**  
19**42** to **date** 19**43**  
that I last saw h. **or** alive on **2-2-** 19**43**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Sarcoma pelvis bone** Duration **1 year**

Due to  
Due to  
Other conditions (Include pregnancy within 3 months of death) **154**

PHYSICIAN  
Major findings: **554**  
Of operations  
Of autopsy  
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) (e) Means of injury

23. Signature **Frank H. Rose** (M. D. or other) **M.D.**  
Address **Albany, Mo.** Date signed **3-3-43**

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 me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Clifford Brooks

Licensed Embalmer No. 3329

P. O. Address Albany 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, fact should be so stated above.**