

FILED DEC 3 1943

Registration District No. 1749

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County JACKSON  
(b) City or town KANSAS CITY MO  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: RESEARCH HOSPITAL  
(If not in hospital or institution, write street number and location)  
(d) Length of stay: In hospital or institution 17 days  
(Specify whether years, months or days) 17 days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LAFAYETTE  
(c) City or town MAYVIEW MO  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JAMES L. ASHFORD

3. (b) If veteran, name war NO 3. (c) Social Security No. 494-12-7044

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife PAULINE ASHFORD 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased DEC 20 1881  
(Month) (Day) (Year)

8. AGE: Years 61 Months 11 Days 0 If less than one day hr. \_\_\_\_\_ min.

9. Birthplace EL PASO TEXAS  
(City, town, or county) (State or foreign country)

10. Usual occupation CARPENTER

11. Industry or business BUILDING

MOTHER FATHER  
12. Name ROSE ASHFORD  
13. Birthplace UNKNOWN 9  
(City, town, or county) (State or foreign country)  
14. Maiden name UNKNOWN  
15. Birthplace UNKNOWN 9  
(City, town, or county) (State or foreign country)

16. (a) Informant MRS J. L. ASHFORD

(b) Address MAYVIEW MO

17. (a) REMOVAL (b) Date thereof NOV 20 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mayview, Mo.

18. (a) Signature of funeral director James Funeral Home

(b) Address Concordia, Missouri

19. (a) 11-22-43 (b) J. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. 20 day 1943 hour 1:30 minute A.M.

21. I hereby certify that I attended the deceased from 11-3-43 to 11-20-43, 1943, that I last saw him alive on 11/19/43, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia 2 ✓

Due to Perforated peptic ulcer 11 ✓

Due to Low arterial sclerosis

Other conditions: Low arterial sclerosis  
(Include pregnancy within 3 months of death)

Major findings: Perforated peptic ulcer PHYSICIAN  
Of operations Above

Of autopsy Above  
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? John W. Fisher M.D. (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature John W. Fisher M.D. (M.D. or other)  
Address 830 Apple Bldg R.R. Date signed 11/20/43

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

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**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..... *Harlyn Roe* .....

Licensed Embalmer No. *1078* .....

P. O. Address *K.C., 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.**