

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25243

State File No. _____

FILED JUL 24 1944 228

Registration District No. _____ Primary Registration District No. 5096

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Montgomery
 (b) City or town Bellflower (Rural)
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Bellflower Home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 Year
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Martha Lee Aston

3. (b) If veteran, name war None
 3. (c) Social Security No. None

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife None
 6. (c) Age of husband or wife if alive 7 years
 7. Birth date of deceased January 7
 (Month) (Day) (Year)

8. AGE: Years 2 Months 5 Days 5
 If less than one day hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business _____

12. Name Kenneth Aston
 13. Birthplace Montgomery Co Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Agness N Waible
 15. Birthplace Plevna Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant Kenneth L Aston
 (b) Address Bellflower Mo.

17. (a) Burial (b) Date thereof 6-13-1944
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellflower Mo.

18. (a) Signature of funeral director Aland G. Jones

(b) Address Bellflower Mo.

19. (a) June 17-44 (b) Lillian Gaffney
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery
 (c) City or town Bellflower (Rural)
 (If outside city or town limits, write "RURAL")
 (d) Street No. Home
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12
 year 1944 hour 7:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from June 11, 1944, to June 12, 1944,
 that I last saw her alive on June 12, 1944,
 and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Decompensation
Satur
 Due to Bronchial Pneumonia 3 day

Due to Spinal Bifida
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____
 157b

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)
 (e) Means of injury _____

23. Signature A. H. K. K. K. (Type or other)
 Address Montgomery City Date signed 6/13/44

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 91

Dist. File Number.....

Date Recd. 7-21-44

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.....

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

Signed..... *Clarence A. Jones*.....

Licensed Embalmer No. 2978

P. O. Address Bellflower 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.

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