

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14693

State File No.

FILED APR 19 1945
Registration District No. 2 22

Primary Registration District No. 3074

Registrar's No.

1. PLACE OF DEATH:

(a) County Sebastian
(b) City or town Sebastian
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sebastian General Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 wks (Specify whether)
In this community 3 wks years, months or days

3. (a) PRINT FULL NAME

SOPHIA ANN ASHER

3. (b) If veteran, name war L

3. (c) Social Security No. L

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife July 26 1896 6. (c) Age of husband or wife if alive 1 years
(Month) (Day) (Year)

8. AGE: Years 68 Months 7 Days 8 If less than one day hr. min.

9. Birthplace Princeton Ky. (City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER
12. Name Lemuel Morgan
13. Birthplace Uniontown Ky. (City, town, or county) (State or foreign country)
14. Maiden name Mary Gray
15. Birthplace Uniontown Ky. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Asher
(b) Address Charter Oak, Mo.

17. (a) Burial (b) Date thereof 3-5-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Matthews, Mo.

18. (a) Signature of funeral director Orville Taylor
(b) Address Sebastian, Mo.

19. (a) 4/7/45 (b) Louise Largent
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town Charter Oak 72
(If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country L

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4
year 1944 hour 11 minute 45 P.M.

21. I hereby certify that I attended the deceased from 1-15
1945, to 3-4 1945
that I last saw him alive on 3-4 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Cardio-Renal Disease
Duration ?

Due to 1310
Due to 1310

Other conditions Bronchopneumonia 5410
(Include pregnancy within 3 months of death)

Major findings: Cerebral Deceleration of foot
of operations

Of autopsy

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 J. C. M. Chase (M. D. or other)
Address Sebastian, Mo. Date signed 3/13/45

RECEIVED

District Health Office No. 2,

District File Number

Date filed

445-606
4/14/45

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.

Body Not Embalmed

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, fact should be so stated above.