

U.S. No. 2
FORM-5-42
Rev. 5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 7 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23714

State File No.

Registration District No. 65

Primary Registration District No. 4114

Registrar's No.

1. PLACE OF DEATH:

(a) County Chariton

(b) City or town Mendon Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Chariton

(c) City or town Mendon
(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 Samuel Asbell

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced, married

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

7. Birth date of deceased April 12 1868
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>3</u>	<u>9</u>	hr. min.

9. Birthplace Glasford Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Merchant

11. Industry or business.....

12. Name Albert Asbell

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

14. Maiden name Sarah M. Watson

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

16. (a) Informant Earl Asbell
(b) Address Mendon Mo.

17. (a) Burial (b) Date thereof 7/23/45
(Burial, cremation, or removal) (Month) (Day) (Year)
Summer 1945

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address Mendon Mo.

19. (a) July 23, 1945 (b) J. L. Hines
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21st
year 1945 hour 2 minute 10 P.M.

21. I hereby certify that I attended the deceased from July 11
1945, to July 21 1945
that I last saw him alive on July 21 1945
and that death occurred on the date and hour stated above.

Immediate Cause of death Cama
Following Paralysis
of intellectual tract
following the previous 10
days of mental distress
previous history of
paralysis about 1 year ago.

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death).....

Duration 100 days

Major findings: Of operations.....
Of autopsy.....

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)
(a) Means of injury.....

23. Signature W. D. West (M. D. number)
Address Mendon Mo Date signed 7/23/45

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

102 x

(Licensed Embalmer's Statement on Reverse Side)

AUG 20 1945

RECEIVED

District Health Officer No. 8,
District File Number.....

Date Filed 8-6-45

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.

Signed H. L. Leonard

Licensed Embalmer No. 3970

P. O. Address Mendon 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.