

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

State File No. \_\_\_\_\_  
Registrar's No. **3522**

Registration District No. **149** Primary Registration District No. **1002**

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

**1. PLACE OF DEATH:**  
(a) County **Jackson**  
(b) City or town **Kansas City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **General Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **8 Days** (Specify whether  
In this community **16 Years** (Specify whether  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Missouri** (b) County **Jackson 48**  
(c) City or town **Kansas City** **3**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3026 Jackson** **8**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **Anna A. Asher**  
**3. (b) If veteran,** name war **NO** **3. (c) Social Security** No **None**

**4. Sex** **Female** / **5. Color or race** **White**  
**6. (a) Single, widowed, married,** divorced **Widow 2**  
**6. (b) Name of husband or wife** **Samuel Asher** **6. (c) Age of husband or wife if** alive \_\_\_\_\_ years  
**7. Birth date of deceased** **11 14 1853**  
(Month) (Day) (Year)

**8. AGE:** Years Months Days If less than one day  
**91 9 7** hr. min.

**9. Birthplace** **Missouri** **0**  
(City, town, or county) (State or foreign country)

**10. Usual occupation** **At Home**

**11. Industry or business**

**12. Name** **Peter View**

**13. Birthplace** **Maine** **1**  
(City, town, or county) (State or foreign country)

**14. Maiden name** **No Record**

**15. Birthplace** **No Record** **0**  
(City, town, or county) (State or foreign country)

**16. (a) Informant** **Mr. John E. Asher**

**(b) Address** **3026 Jackson**

**17. (a) Burial** **(b) Date thereof** **8-23-1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** **Memorial Park**

**18. (a) Signature of funeral director** **Mrs. C. L. Forster**

**(b) Address** **Kansas City Missouri**

**19. (a) 8-23-45** **(b) Geraldine Holme**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **August** day **21**  
year **1945** hour **9** minute **50** **A** M.

**21. I hereby certify that I attended the deceased from** **August 18 45** to **August 21 45**  
that I last saw her alive on **August 21 1945**  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
**bronchogenic carcinoma**  
**arteriosclerosis**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy **see above**

**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** **Frank W. Seely** **(b) D. October**  
**Med. Dir. N. General Hospital**  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

**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..... *C. H. Wise*.....

Licensed Embalmer No. *2570*.....

P. O. Address..... *K O Md*.....

**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.**