

FILED SEP 12 1945

Registration District No. **174**

Primary Registration District No. **3035**

Registrar's No. **38**

1. PLACE OF DEATH:

(a) County **Lafayette**
(b) City or town **Livingston**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **725 Highland ave**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Life** (Specify whether years, months or days)
In this community **Life**

3. (a) PRINT FULL NAME **MAYME K. ASHFORD**

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

4. Sex **Female** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife **—** 6. (c) Age of husband or wife if alive **25** years (Day) (Year)
7. Birth date of deceased **Sept 25 1879** (Month) (Day) (Year)

8. AGE: Years **66** Months **8** Days **6** If less than one day hr. min.

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

10. Usual occupation **at home**

11. Industry or business

12. Name **Wm W. Ashford**
13. Birthplace **not known** (City, town, or county) (State or foreign country)
14. Maiden name **not known**
15. Birthplace **—** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Howard Shum**

(b) Address **Livingston, Mo**

17. (a) **Burial** (b) Date thereof **9-2-45** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Livingston, Mo**

18. (a) Signature of funeral director **Garret J. Temple**

(b) Address **Livingston, Mo**

19. (a) **Sept. 6-45** (b) **Mrs. Fred Schurb** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Lafayette**
(c) City or town **Livingston** (If outside city or town limits, write "RURAL")
(d) Street No. **725 Highland** (If rural, give location)
(e) Citizen of foreign country? **—** (Yes or No)
If yes, name country **—**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **1** year **1945** hour **12** minute **01 A.M.**

21. I hereby certify that I attended the deceased from **June 30** 1945 to **July 1** 1945
that I last saw her alive on **June 30** 1945 and that death occurred on the date and hour stated above.

Immediate cause of death **—** Duration **—**

Due to **Cerebral Hemorrhage**

Due to **—**

Other conditions **Thrombosis** (Include pregnancy within 3 months of death)

Major findings: Of operations **—**

Of autopsy **None**

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 **Edt. Freden dall** (M. D. or other) Address **Livingston, Mo** Date signed **7/2/45**

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

RECEIVED

District Health Officer No. 8.

District File Number.....

Date Filed 9-10-72

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.....

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.