No. 2
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I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 4 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

31210

State File No.

Registration District No. 280 Primary Registration District No. 6296-9 Registrar's No. 18

1. PLACE OF DEATH:

(a) County Platte

(b) City or town Beverly, Mo. Fair Tomorrow
(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
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Leavenworth 999

(c) City or town Leavenworth, Kansas 4
(If outside city or town limits, write "RURAL")

(d) Street No. 816 Maple Ave. 0
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 2

If yes, name country

3. (a) PRINT FULL NAME Albert J. Asbury

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male 1

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Irma Asbury

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

7. Birth date of deceased 3 (Month) 28 (Day) 1908 (Year)

8. AGE: Years 37 Months 5 Days 24 If less than one day hr. min.

9. Birthplace Bucanan Co. (City, town, or county) Missouri 6 (State or foreign country)

10. Usual occupation Newspaper Distributor

11. Industry or business ff ff

MOTHER FATHER

12. Name C. C. Asbury

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

MOTHER

14. Maiden name Elsie Asbury

15. Birthplace Bucanan Co. (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Don Myers-Sheriff

(b) Address Platte City, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-20-45 (Month) (Day) (Year)

(c) Place: burial or cremation Leavenworth, Kans.

18. (a) Signature of funeral director Sexton Undertaking Co.

(b) Address Leavenworth, Kansas

19. (a) 9-20-45 (Date received local registrar) (b) [redacted] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. 20 day

year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;

that I last saw h alive on , 19 ;

and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Fracture of Skull due to automobile accident	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) Accident, ~~suicide, or homicide~~ (specify) Accident 93

(b) Date of occurrence Sept 20, 1945

(c) Where did injury occur? Public Highway (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
public highway (Specify type of place)

While at work? yes (e) Means of injury

23. Signature Tom H. Hulett 2 (M. D. or Other) Coroner

Address Platte City, Mo. Date signed 9-20-45

1484 (Licensed Embalmer's Statement on Reverse Side)

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 Francis W Giffee

Licensed Embalmer No. 4393

P. O. Address Platte City, [illegible]

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.

S. No. 2B
M—3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31210

Registration District No. ____ Primary Registration District No. ____ Registrar's No. ____

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

1. PLACE OF DEATH:

(a) County Platte

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

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State ____ (b) County ____

(c) City or town ____
(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 Albert J. Asbury

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex ____

5. Color or race ____

6. (a) Single, widowed, married, divorced ____

6. (b) Name of husband or wife ____

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

7. Birth date of deceased ____ (Month) ____ (Day) ____ (Year)

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

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

10. Usual occupation ____

11. Industry or business ____

FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) ____ (State or foreign country)

MOTHER
14. Maiden name ____
15. Birthplace ____ (City, town, or county) ____ (State or foreign country)

16. (a) Informant ____
(b) Address ____

17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____

18. (a) Signature of funeral director ____
(b) Address ____

19. (a) ____ (Date received local registrar) (b) ____ (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month ____ Day ____ year ____ hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19____ to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death ____	
State Highway Patrol	
Due to ____	
Car ran off roadway	
Due to ____	
Other conditions (Include pregnancy within 3 months of death) ____	
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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature ____ (M. D. or other) ____

Address ____ Date signed ____