

S. No. 2  
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5-17-39  
P I X37823

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF THE CENSUS  
FILED MAR 27 1946 STANDARD CERTIFICATE OF DEATH

10439

State File No. \_\_\_\_\_

Registration District No. 292

Primary Registration District No. 6000

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Ralls  
(b) City or town Rural - Jasper Township  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
7 MILES NORTH OF VANDALIA  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days 2 yrs (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County RALLS #17  
(c) City or town RURAL - JASPER TOWNSHIP  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7 MILES NORTH OF VANDALIA  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN LAFAYETTE ASBURY  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. NONE

20. DATE OF DEATH: Month 2 day 22  
year 1946 hour 9 minute 30 A.M.

MEDICAL CERTIFICATION

4. Sex MALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced Wid  
6. (b) Name of husband or wife CATHERINE ASBURY 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept 4 1862  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2/15, 1946 to 2/22, 1946  
that I last saw him alive on 2/22, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis 1 yr  
Due to upper respiratory infection 5 days  
Due to Chronic Bronchitis 2 yrs  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
83 5 18 hr. min.  
9. Birthplace GREENBURG MISSOURI  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

10. Usual occupation FARMER  
11. Industry or business FARMING  
12. Name BLACKSTONE ASBURY  
13. Birthplace KENTUCKY  
(City, town, or county) (State or foreign country)

14. Maiden name MARY LESTER  
15. Birthplace COVINGTON KENTUCKY  
(City, town, or county) (State or foreign country)  
16. (a) Informant Mrs. Robert Mc Bride  
(b) Address Vandalia, Mo.  
17. (a) Burial (b) Date thereof FEB 24 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation VANDALIA CEMETRY  
18. (a) Signature of funeral director W. B. Waters  
(b) Address Vandalia, Mo.  
19. (a) FEB 23 1946 (b) Clydesmith  
(Date received local registrar) (Registrar's signature)

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 Thos. J. Swyer (M. D. \_\_\_\_\_)  
Address Vandalia, Mo. Date signed 2/23/46

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

DEC 1 1 1953

NOV 25 1955

RECEIVED

District Health Officer No. 10

District File Number 3-46-619

Date Filed MAR 22 1946

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 William B. Natus

Licensed Embalmer No. 4169

P. O. Address Vandalia 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. *April*Registration District No. *292*Primary Registration District No. *6000*

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

- (a) County..... *Ralls*  
 (b) City or town..... *Rural*  
 (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..... (Specify whether

In this community..... (Specify whether  
years, months or days)3. (a) PRINT  
FULL NAME*John L. Asbury*

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.....
- WIDOWED*

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

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

7. Birth date of deceased.....
- Sept*

(Month)

(Day)

(Year)

## 8. AGE:

Years

Months

Days

If less than one day

*83*

hr.

min.

9. Birthplace.....
- MO*

(City, town, or county)

(State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

(City, town, or county)

(State or foreign country)

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)
- Clyde W. Wilby*

(Registrar's signature)

## 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.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....
- 7*
- day.....
- 12*
- 
- year.....
- 1946*
- hour..... minute..... M.

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

that I last saw him..... alive on....., 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Duration

Due to.....

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?

While at work?..... (Specify type of place)  
(e) Means of injury.....

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

Address..... Date signed.....

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

SUPPLEMENTARY

10439