

S. No. 2
M-5-43
5-17-39
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DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS
FILED AUG 20 1946 STANDARD CERTIFICATE OF DEATH

28404

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6864**

1. PLACE OF DEATH:

(a) County.....
 (b) City or town **St. Louis**
 (If outside city or town limits, write "RURAL," and name of township)
 (c) Name of hospital or institution:
Desloge Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **10 days**
 In this community **50 years**
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis 9'**
 (c) City or town **St. Louis Lakewood**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **5223 Vine Str.**
 (If rural, give location) **N.R.**
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **Asbury, (Elmer)**
 3. (b) If veteran, name war.....
 3. (c) Social Security No. **2**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **3** year **1946** hour **5** minute **40 A.M.**
 21. I hereby certify that I attended the deceased from **July 24, 1946** to **Aug 3, 1946**
 that I last saw him alive on **Aug 2, 1946** and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Anna**
 6. (c) Age of husband or wife if alive **60** years
 7. Birth date of deceased **Nov. 22 1878**
 (Month) (Day) (Year)

Immediate cause of death **Myocardial Infarction**
 Due to **Coronary Occlusion, Anterior Artery**
 Due to **137A**
 Other conditions **Prostatic Hypertrophy**
 (Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
67 **8** **11** hr. min.

Major findings: **Prostatic Hypertrophy**
 Of operations.....
 Of autopsy **Myocardial Infarction Prostatic Hypertrophy**

9. Birthplace **Salem Illinois**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Maintenance Man**

11. Industry or business **Retired**

12. Name **Wm. Asbury**

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

14. Maiden name **Steeley**

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

16. (a) Informant **Anna Asbury**

(b) Address **5223 Vine Str.**

17. (a) **Burial** (b) Date thereof **8-6-46**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Burial Park**

18. (a) Signature of funeral director **J.L. Ziegenhein & Sons**
 (b) Address **2027 Gravois**

19. (a) **AUG 6 1946** (b) **J.T. Bredeck**
 (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 **0**

23. Signature **Amal D. Guni, M.D.** M.D. or other

Address **1001 Desloge Plaza** Date signed **8/13/46**

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

MOTHER FATHER

0
7
9

FILED MAR 20 1964

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 W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address Overland 14 7

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.