

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 21 1947

Registration District No.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No.

6093

State File No.

Registrar's No.

3634

9

1. PLACE OF DEATH

(a) County Saline
(b) City or town Marshall Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo State School 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 yrs
(Specify whether
In this community
years, months or days)

3. (a) PRINT
FULL NAME

Oliver Asher

3. (b) If veteran,
name war

3. (c) Social Security
No. 210

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive 9 years
7. Birth date of deceased: Aug 1913
(Month) (Day) (Year)

8. AGE: Years 32 Months 4 Days 28
If less than one day hr. min.

9. Birthplace: James Prairie - Dent Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Patient

11. Industry or business
12. Name James Oliver Asher
13. Birthplace Dent Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Jessie Neighbors
15. Birthplace Phelps Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Records Mo State School
(b) Address Marshall, Mo

17. (a) Funeral (b) Date thereof Jan 5 - 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial - Mo

18. (a) Signature of funeral director Camille Lewis
(b) Address Marshall Mo

19. (a) 1-4-47 (b) Mrs. O. Weathers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent Co. 97
(c) City or town James Prairie
(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

23. DATE OF DEATH: Month Jan day 2
year 1947 hour minute 8:40 P.M.

21. I hereby certify that I attended the deceased from Jan 2, 1947, to Jan 2, 1947.
that I last saw him alive on Jan 2 - 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: Post-Encephalitis
Post-Encephalitis

Due to Encephalitis

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations GUB
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? (c) Means of injury

23. Signature L.S. James M.D. (M. D. or other)
Address Marshall, Mo Date signed 1-2-47

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

294

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 1-18-47

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. 3469

P. O. Address Marshall, 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.