

No. 2
-12-45
17-39
X47070

FILED MAR. 11 1947

Registration District No. Primary Registration District No. **5843**

1. PLACE OF DEATH:

(a) County Missouri (b) City or town Hornet
(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 yes years, months or days _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newtown
(c) City or town Spring City
(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 Wm. Oscar Asher

3. (b) If veteran, name war _____ **3. (c) Social Security** No. 500-01-6727

4. Sex Male **5. Color or race** White

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

6. (b) Name of husband or wife Oscar Asher **6. (c) Age of husband or wife if** 52 years
alive _____

7. Birth date of deceased Aug 20 1890
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>56</u>	<u>5</u>	<u>30</u>	hr. _____ min. _____

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

10. Usual occupation Roofer

11. Industry or business _____

12. Name Oscar Asher **9**

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

14. Maiden name Mary Bailey

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

16. (a) Informant John Asher

(b) Address Spring City

17. (a) (Burial, cremation, or removal) Burial **(b) Date thereof** Feb 25 1947
(Month) (Day) (Year)

(c) Place: burial or cremation Palmyra Missouri

18. (a) Signature of funeral director Miss City Wash Co

(b) Address Miss City

19. (a) (Date received local registrar) March 6 '47 **(b) (Registrar's signature)** Nathan Norris

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 19
year 1947 hour 5:15 minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him alive on Feb. 19 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Heart block

Due to acute Indigestion

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

Duration

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? _____ **(c) Means of injury** _____

23. Signature J. S. Mendenhall (M. D. or other) do
Address Jerreca mo **Date signed** Feb 25

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

73
0
0
0

RECEIVED

Sanitary Health Officer No. Newton

Case File Number 347-47

Filed 3-10-47

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.....

Harvey E. Arnce

Registered Apprentice No. 412

working under my personal supervision.

Signed A. K. Mills

Licensed Embalmer No. 347

P. O. Address Webb City, Missouri

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.

Registration District No. 248

Primary Registration District No. 5843

1. PLACE OF DEATH

(a) County Newton
(b) City or town Stonev
(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 _____ years, months or days

3. (a) PRINT FULL NAME

Wm B. Asher

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 m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased Aug 20 1874
(Month) (Day) (Year)

8. AGE: Years 56 Months _____ Days _____ (Unless than one day) hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Newton
(c) City or town Stonev
(If outside city or town limits, write "RURAL")
(d) Street No. 10 miles S. Opinel
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 _____

SUPPLEMENTARY

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

~~SECRET~~

S-5594