

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12147

FILED MAR 21 1947

Registration District No. 21

Primary Registration District No. 61161

Registrar's No. 12147

1. PLACE OF DEATH:

(a) County Stone
(b) City or town Cape Fair Mrs. Rural
(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 1 (Specify whether years, months or days)
In this community 1 years, months or days

3. (a) PRINT FULL NAME MARIE ASHER.

3. (b) If veteran, name war 1 3. (c) Social Security No. 1

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife 1 6. (c) Age of husband or wife If alive 1912 years (Day) (Year)

7. Birth date of deceased May (Month) 7 (Day) 1912 (Year)
8. AGE: Years 34 Months 8 Days 9 If less than one day hr. 1 min. 1

9. Birthplace Cape Fair Mrs. Rural (City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business 1

12. Name John S. Asher
13. Birthplace Cape Fair Mo. (City, town, or county) (State or foreign country)
14. Maiden name Minnie Foster
15. Birthplace Cape Fair Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Elvin Carney
(b) Address Cape Fair Mo.
17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-18-47 (Month) (Day) (Year)

(c) Place: burial or cremation Summer Green Park
18. (a) Signature of funeral director Charles Funeral Home
(b) Address Cassville, Missouri

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stone
(c) City or town Cape Fair Rural (If outside city or town limits, write "RURAL")
(d) Street No. 5 West Cape Fair Mrs. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 16 year 1947 hour 6 A. minute 7 M.
21. I hereby certify that I attended the deceased from March 1 1946 to Jan-16 1947
that I last saw her alive on Dec-23 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 1 yr.
Due to usual

Due to 13 B
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 13 B
Of autopsy 1
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) 1
(b) Date of occurrence 1
(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) (c) Means of injury 1
23. Signature H. D. Felt (M. D. or pathologist)
Address Crane Mo. Date signed 1-17-47

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

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 Margaret Culver

Licensed Embalmer No. 4389

P. O. Address Crossville

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.