No. 1
—5-43
5-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 1 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14248

Registration District No. 2/3 Primary Registration District No. 5781 Registrar's No. 4

1. PLACE OF DEATH:
(a) County Miller (b) City or town RURAL Glaze
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: KAISER
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution —
(Specify whether years, months or days)
In this community Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Miller 66
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. KAISER
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country none

3. (a) PRINT FULL NAME Rosie-May-Asa
3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife Clarence-Asa 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased MAY (Month) 5 (Day) 1890 (Year)

8. AGE: Years 56 Months 11 Days 29 If less than one day — hr. — min.

9. Birthplace Monitau-Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation House-wife

11. Industry or business Home

FATHER 12. Name James-Byrd-
13. Birthplace unknown (City, town, or county) Mo (State or foreign country)

MOTHER 14. Maiden name Matilda-Reed
15. Birthplace unknown (City, town, or county) Mo (State or foreign country)

16. (a) Informant Clarence Asa
(b) Address Kaiser Mo

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-25-47 (Month) (Day) (Year)
(c) Place: burial or cremation New-Hope-Cem

18. (a) Signature of funeral director Keith McKay
(b) Address Eldon Mo

19. (a) April 26, 1947 (Date received local registrar) (b) Mrs. C. R. Hawkins (Registrar's signature) 102

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 24 year 1947 hour 12 minute 30 A.M.

21. I hereby certify that I attended the deceased from APRIL 19 1947 to APRIL 24 1947 that I last saw h[illegible] alive on APRIL 23 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: ACUTE MYOCARDITIS	
FAILURE	
Due to: VALVULAR HEART	
DISEASE	3 mo.
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature H. B. Lehner MD (M. D. or other)
Address Osage Beach Mo Date signed May 29

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed
MAY 20 1947

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was Not embalmed by me, or by .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed Keith M. Kayd.

Licensed Embalmer No. 3988

P. O. Address Eldon 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.