

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 13219

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 1/2 hrs.  
(Specify whether  
In this community 20 years  
years, months or days)

3. (a) PRINT FULL NAME

Ora Ashley

3. (b) If veteran, name war No

3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife Nettie 6. (c) Age of husband or wife if alive years

7. Birth date of deceased: June 23 1873  
(Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days 13 If less than one day hr. min.

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

10. Usual occupation retired

11. Industry or business Insurance Collector

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Roy Hartsell

(b) Address 2918 Woodland

17. (a) removal (b) Date thereof 4-8-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cem. K.C. Ks.  
Melody-McGilley-Eylar

18. (a) Signature of funeral director Melody-McGilley-Eylar

(b) Address 1800 Linwood Blvd.

19. (a) 4-7-48 (b) Sheldine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2918 Woodland  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6  
year 1948 hour 2 minute 45 P. M.

21. I hereby certify that I attended the deceased from April 5 1948 to April 6 1948; that I last saw him alive on April 6 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 94a

Of autopsy None

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? (Specify type of place) (e) Means of injury (1)

23. Signature [Signature] (M. D. or other) MD  
Address Med. Dir. Gen'l Hosp Date signed 4-7-48

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

8308

*Dr. Taylor*

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**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.....

P. O. Address.....

**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.**