No. 2
5-43
17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28546

FILED SEP 10 1948

Registration District No. 224 Primary Registration District No. 3072 Registrar's No. 180

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: Fitzgibbons Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 Days (Specify whether years, months or days)

In this community 37 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline

(c) City or town Shackelford Rural
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. ½ mi. W. of Shackelford
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME George Buckner Ash

3. (b) If veteran, name war #

3. (c) Social Security No. #

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Leona Maupin Ash

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased January (Month) 22 (Day) 1871 (Year)

8. AGE: Years 77 Months 7 Days 0 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name William Francis Ash
13. Birthplace Rapahanna Co. (City, town, or county) Virginia (State or foreign country)

MOTHER
14. Maiden name Mary Frances Elsie
15. Birthplace Rapahanna Co. (City, town, or county) Virginia (State or foreign country)

16. (a) Informant Mrs. G. B. Ash

(b) Address Shackelford, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/48 (Month) (Day) (Year)

(c) Place: burial or cremation Sunset M. Gardens Marshall Mo.

18. (a) Signature of funeral director [illegible]

(b) Address Marshall Mo.

19. (a) Aug. 24 1948 (Date received local registrar) (b) Sidney T. Gray (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 22 year 48 hour 7 minute 10 P.M.

21. I hereby certify that I attended the deceased from July 1 1948 to Aug 22 1948 and that I last saw him alive on Aug 22 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Fracture of hip	8/14/48
Due to: Hemiplegia	1945
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.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 [illegible] (M. D. or other)

Address Marshall Mo. Date signed 8/23/48

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9-9-43

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 J. Lalie Summey

Licensed Embalmer No. 3235

P. O. Address Marshall, Tx

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.

No. 2B
3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 54-A

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 1780

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall
(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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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 George B. Ash

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 years

7. Birth date of deceased Jan 22 (Month) (Day) (Year)

8. AGE: Years 77 Months Days Unless than one day hr. min.

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

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 22 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — *Duration*

Due to

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) Accident Fall

(b) Date of occurrence Aug 10-48

(c) Where did injury occur? (City or town) (County) (State) Home

(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 fell

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

28546