

FILED OCT 15 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 30243

Registration District No. 771

Primary Registration District No. 5637

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Lafayette  
(b) City or town Clay Twp. Odessa Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4 mi. North  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 65 yr 3 mo 8 da. (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Walter Ashcraft

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

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

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

7. Birth date of deceased June 5 1883  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
65 3 8 hr. min.

9. Birthplace 4 mi. N. Odessa MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name John Ashcraft  
13. Birthplace unknown KY  
(City, town, or county) (State or foreign country)

14. Maiden name Makron Barker  
15. Birthplace Lafayette Co. MO  
(City, town, or county) (State or foreign country)

16. (a) Informant James Ashcraft  
(b) Address Odessa Mo.

17. (a) Burial (b) Date thereof Sept 15 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greentown Cem

18. (a) Signature of funeral director Blair Huns  
(b) Address Odessa Mo.

19. Sept 15 1948 (Date received local registrar) (M. D. certified)  
(Registrar's signature) 15 5

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette  
(c) City or town Rural - Clay Twp  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4 mi. North - Odessa, Mo  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 13  
year 1948 hour 12 minute 10 P. M:

21. I hereby certify that I attended the deceased from 9-3- 1948 to 9-13- 1948  
that I last saw him alive on 9-13- 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis  
ch. myocarditis  
Due to \_\_\_\_\_  
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? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature E. B. Huns (M. D. certified)  
Address Odessa Mo. Date signed 9/15/48

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 10-14-48

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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 Carlton R. Blinn

Licensed Embalmer No. 2945

P. O. Address Adrian, 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.**