

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED NOV 16 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

36295

State File No. _____

Registration District No. 140

Primary Registration District No. 3224

Registrar's No. 69

1. PLACE OF DEATH:

(a) County Howard
(b) City or town Fayette
(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community All his life
years, months or days

3: (a) PRINT FULL NAME Tom Ashcraft

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

4. Sex Male 2 5. Color or race Black 6: (a) Single, widowed, married, divorced Married

6: (b) Name of husband or wife Mary Williams Ashcraft 6: (c) Age of husband or wife if alive 39 years

7. Birth date of deceased August 4, 1894
(Month) (Day) (Year)

8. AGE: Years 54 Months 3 Days 1 If less than one day hr. _____ min. _____

9. Birthplace Howard Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

12. Name John Ashcraft

13. Birthplace Howard Co. Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Frisella Cooper

15. Birthplace Howard Co. Missouri
(City, town, or county) (State or foreign country)

16: (a) Informant Mary Ashcraft

(b) Address Fayette, Missouri

17: (a) Burial (b) Date thereof 11/8/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cem. (Col)

18: (a) Signature of funeral director Ralph A. Carr

(b) Address Fayette, Missouri

19: (a) 11-13-1948 (b) Dorothy Fern Ashcraft
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard 45
(c) City or town Fayette
(If outside city or town limits, write "RURAL")
(d) Street No. 316 E. Morrison St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 5th
year 1948 hour 4:00 minute A. M.

21. I hereby certify that I attended the deceased from June 1948 to Nov. 5 1948
that I last saw him alive on Nov. 2 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic emphysema Duration 1 yr.

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 1102

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 0

23. Signature Dr. J. Shaw (M. D. or other) MD

Address Fayette, Mo. Date signed 11-8-48

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

RECEIVED
District Health Officer No. 8,
District File Number _____
Date Filed 11-15-78

VS
JUN 13 1960

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, ~~only~~ _____

working under my personal supervision.

Registered Apprentice No. _____

Signed _____

Licensed Embalmer No. 3340

P. O. Address Fayette 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.