

No. 2  
1/47  
5-17-39

40724

FEDERAL BUREAU OF INVESTIGATION

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

National Office of Vital Statistics

FILED DEC 20 1948

Registration District No. 198

Primary Registration District No. 5695

Registrar's No. 160

1. PLACE OF DEATH:

(a) County Livingston  
(b) City or town Child-Rural-Cream Ridge  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 65 years.  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston  
(c) City or town Child-Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Cream Ridge Trwp.  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Emma Catherine Ashman.

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed  
6. (b) Name of husband or wife Fuller James Ashman 6. (c) Age of husband or wife if alive 4 years  
7. Birth date of deceased March 15 1868  
(Month) (Day) (Year)

8. AGE: Years 80 Months 8 Days 26  
If less than one day hr. min.

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

10. Usual occupation House Wife

11. Industry or business.....

12. Name Thomas Thompson

13. Birthplace Not Known Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Boyd

15. Birthplace Not Known Penn.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mary A. Marlow  
(b) Address Child, Mo.

17. (a) Burial (b) Date thereof 12/13/1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Plainview

18. (a) Signature of funeral director E. Robertson Funeral Home  
(b) Address Child, Mo.

19. (a) Dec 14 1948 (b) Frances B. Neill  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 11  
year 1948 hour 2 minute 45 P.M.

21. I hereby certify that I attended the deceased from Dec 6 1948 to Dec 11 1948  
that I last saw him alive on Dec 10 1948  
and that death occurred on the date and hour stated above.  
Duration

Immediate cause of death Pneumotitic Pneumonia 2 days  
Severe Dementia

Due to.....  
Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: 1611  
Of operations.....  
Of autopsy.....  
Underline cause of death which death certificate should be charged statistically.

22. If death was due to external causes, fill in the following: REQUESTED

(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 M. DeWitt (M. D. or other)

Address Child, Mo. Date signed 12-13-48

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

MOTHER FATHER

0

M.E. Elliott.

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 John M Robertson  
Licensed Embalmer No. 4388  
P. O. Address Laredo 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. *Jan 160*Registration District No. *187*Primary Registration District No. *5695*

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

(a) County *Livingston Rural*  
(b) City or town \_\_\_\_\_  
(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 \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days3. (a) PRINT FULL NAME *Emma C. Ashman*

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex *F*5. Colour *r* race \_\_\_\_\_6. (a) Single, *wid* widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased *March* (Month) *1943* (Year)8. AGE: Years *80* Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace *Ohio* (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or Business \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

## 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 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
Year *1943* hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death *Tuber. Pneumonia 2 day* 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) \_\_\_\_\_

(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 *M. E. ...* (M. D. or other) \_\_\_\_\_Address *Chillicothe Mo* Date signed *12-23-43*

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

SUPPLEMENTARY

5-40724