

FILED JAN 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 196

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
c. LENGTH OF STAY (In this place) 2 Yrs.		d. STREET ADDRESS (If rural, give location) 2941 Jules	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2941 Jules			

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle) R.	c. (Last) Ashford	4. DATE OF DEATH (Month) (Day) (Year) Jan. 9, 1950
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 8, 1865	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months 6	IF UNDER 1 MIN. Days 1	IF UNDER 1 MIN. Hours
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Editor	10b. KIND OF BUSINESS OR INDUSTRY Newspaper	11. BIRTHPLACE (State or foreign country) Iowa	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME William D. Ashford	13b. MOTHER'S MAIDEN NAME Elizabeth Bond	14. NAME OF HUSBAND OR WIFE Maude C. Ashford
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. unknown	17. INFORMANT'S SIGNATURE OR NAME Maude C. Ashford, St. Joseph, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		2 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c)		5 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			331X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from October 11, 1949, to January 9, 1950, that I last saw the deceased alive on January 9, 1950, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE Nelle D. Turney (Degree or title) J. D.O.	23b. ADDRESS St. Joseph Mo.	23c. DATE SIGNED 1-10-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1/11/1950	24c. NAME OF CEMETERY OR CREMATORY Oak Hill	24d. LOCATION (City, town, or county) (State) Cedar Rapids, Iowa
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DATE REC'D BY LOCAL REG. Jan. 14, 1950	REGISTRAR'S SIGNATURE E. C. Jenkins 382	FUNERAL DIRECTOR'S SIGNATURE Nealon Bowman	ADDRESS St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

0117

0117
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Melle J. Kearney

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Eugene Wood

Licensed Embalmer No. *2804*

P. O. Address *519 So 15th St. Joseph*

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.