

FILED JUN 3 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1957

STATE FILE NUMBER

Registration District No. 347 Primary Registration District No. 6161 Registrar's No. 27

1. PLACE OF DEATH a. COUNTY <u>Stone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Stone</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Flat Creek</u> Inside Limits Yes ☒ No ☐				c. CITY OR TOWN <u>Cape Fair</u> 1048 Inside Limits Yes ☐ No ☒			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If outside, give location) <u>Flat Creek J.W.P.</u> Reside on Farm Yes ☒ No ☐			
3. NAME OF DECEASED (Type or print) <u>Bern</u> First <u>James</u> Middle <u>asher</u> Last				4. DATE OF DEATH <u>May</u> Month <u>13</u> Day <u>1957</u> Year			
5. SEX <u>m</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		8. DATE OF BIRTH <u>Mar. 10-1883</u>	
9. AGE (In years last birthday) <u>74</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Stone Co., Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William asher</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Foster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Albertie asher - Cape Fair Mo</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brunn's Tumor</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>							
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒							
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐				20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			
20f. CITY, TOWN, OR LOCATION				COUNTY		STATE	
21. I attended the deceased from _____, to _____ and last saw her alive on _____ Death occurred at <u>10:50 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Myrtle E. Combs</u>				22b. ADDRESS <u>Cape Fair Mo</u>		22c. DATE SIGNED <u>May 15</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>May 16-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Walter Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Salina Mo</u>	
24. FUNERAL DIRECTOR <u>Ernest J. Cheatham</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>May 17-1957</u>		26. REGISTRAR'S SIGNATURE <u>Myrtle E. Combs</u>	

(Licensed Embalmer's Statement on Reverse Side)

Myrtle E. Combs

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 _____
Signature of Student Embalmer

Signed Ernest J. Cheatham

Licensed Embalmer No. 38

P. O. Address Halena

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.