

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

757 027506
STATE FILE NUMBER

FILED AUG 19 1957

42

Primary Registration District No.

1000

Registrar's No.

876

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, give TOWNSHIP only) OR TOWN St. Joseph			Inside Limits Yes ☒ No ☐	c. CITY OR TOWN St. Joseph		Inside Limits Yes ☒ No ☐	
c. FULL NAME OF (If NOT inhospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hosp.			Length of stay in lb 28 yrs	d. STREET ADDRESS 1110 No. 3rd St.			(If outside, give location) Reside on Farm Yes ☐ No ☒
3. NAME OF DECEASED (Type or print) EFFIE LUNA ASHFORD				4. DATE OF DEATH Month Aug. Day 8 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		8. DATE OF BIRTH Nov. 22, 1878	
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	
10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Clarence Missouri		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Daniel Walker				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Everett Ashford Raytown, Missouri			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myo cardial infarction with cardiac decompensation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4201							
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2							
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. _____		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 8-7-57 to 8-8-57 and last saw ~~him~~ her alive on 8-8-57 Death occurred at 7:30A m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Anna O'Leary M.D.</i> (Degree or title)				22b. ADDRESS Tootle Building St. Joseph, Mo.		22c. DATE SIGNED 8-9-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8-10-57		23c. NAME OF CEMETERY OR CREMATORY Belmont Cemetery		23d. LOCATION (City, town, or county) (State) Wathena Kansas	
24. FUNERAL DIRECTOR <i>Stoney Funeral Home</i> ADDRESS St. Joseph, Mo.				25. DATE RECD. BY LOCAL REG. Aug. 16, 1957		26. REGISTRAR'S SIGNATURE <i>Mrs. Robert Fulton</i>	

(Licensed Embalmer's Statement on Reverse Side)

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 George A. Kerby

Licensed Embalmer No. 447

P. O. Address St. Louis

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.