

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-024631**

**FILED VS JUL 20 1959**

Registration District No. 100 Primary Registration District No. 3018 Registrar's No. 51

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Dent County</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Dent</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Salem, Missouri</b>		Length of stay in lb <b>10 yrs.</b>	c. CITY OR TOWN <b>Salem, Missouri</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>11th Street Salem, Missouri</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>11th Street Salem, Missouri</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Maude</b> Middle <b>Lee</b> Last <b>Asher</b>			4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>1959</b>			
---	--	--	--	--	--	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-6-1884</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-------------------------	----------------------------------	---	-------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Housekeeping</b>	11. BIRTHPLACE (City and state or country) <b>Dent County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
---	--	---	--

13a. FATHER'S NAME <b>H. D. Whitaker</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Smith</b>	14. NAME OF HUSBAND OR WIFE <b>Andrew Asher</b>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Jesse Holmes Salem, Mo.</b>	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) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral Arteriosclerosis</b>		<b>2 yrs.</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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
---	--	---	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 <b>3-8-59</b> to <b>7-17-59</b> and last saw her/him alive on <b>7-17-59</b>
Death occurred at <b>11:30 AM</b> <input checked="" type="checkbox"/> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Ray Mitchell, M.D.</b> (Degree or title)	22b. ADDRESS <b>Salem, Mo.</b>	22c. DATE SIGNED <b>7-18-59</b>
---	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>July 19, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>	23d. LOCATION (City, town, or county) <b>Dent County, Missouri</b>
---	-----------------------------------	---	---

24. FUNERAL DIRECTOR <b>SPENCER FUNERAL HOME, Salem, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>7/18/59</b>	26. REGISTRAR'S SIGNATURE <b>M. M. Hart, M. D. Ly Ann</b>
---	---------	--	--

BY AFFIDAVIT OF DOCUMENT MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*Carl H. [Signature]*

Licensed Embalmer No. 237

P. C. Address: Palmer

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING (Failure to do so 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.