

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 18 1959 74

59-031324

STATE FILE NUMBER

DED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 21

1. PLACE OF DEATH a. COUNTY <u>Worth County Missouri</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Worth</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Grant City Missouri</u>		Length of stay in 1b <u>18 months</u>		c. CITY OR TOWN <u>Worth</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>800 South Lyons St.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>North-West Part</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Alva</u> Last <u>Asher</u>				4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-24 1873</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>27</u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired farmer</u>		11. BIRTHPLACE (City and state or country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Harry Asher</u>		13b. MOTHER'S MAIDEN NAME <u>Henretta Maxwell</u>		14. NAME OF HUSBAND OR WIFE <u>Nora Ellen Asher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Charley Asher, Worth Missouri</u>			
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>NEURULARY FAILURE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CEREBRAL HYPOXIA</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CARCINOMA OF PROSTATE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 HOURS</u> <u>3 WEEKS</u> <u>YEARS</u>	
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 <u>  </u> a.m. <u>  </u> p.m. Month, Day, Year <u>  </u>		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 <u>FEB. 1957</u> to <u>JULY 21, 1959</u> and last saw her/him alive on <u>JULY 17, 1959</u> Death occurred at <u>6:50 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Richard J. Smith, D.O.</u> (Degree or title)				22b. ADDRESS <u>GRANT CITY</u>		22c. DATE SIGNED <u>7-23-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 23-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Barnes Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>1 mile West North Mo</u>	
24. FUNERAL DIRECTOR <u>Elmer R. [Signature]</u>		ADDRESS <u>[Address]</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 12, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Dawney Kibbe</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Clair D Rhoads, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Clair D Rhoads

Licensed Embalmer No. 4759

P. O. Address Mt Airy, N.C.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.