

# MICHIGAN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 13 1959

59-032140

Registration District No. 140 Primary Registration District No. 5542 Registrar's No. 86 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Howard</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Howard</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bonne Femme Twp.</b>		Length of stay in 1b <b>15 yrs</b>	c. CITY OR TOWN <b>Higbee</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>R. R. #2 Higbee, Mo</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>R. R. #2</b>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print) First <b>HENRY</b> Middle <b>OWEN</b> Last <b>ASBURY</b>			<b>4. DATE OF DEATH</b> Month <b>Oct.</b> Day <b>6,</b> Year <b>1959</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>7/21/1896</b>	<b>9. AGE (last birthday)</b> <b>63</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>15</b> Hours <b></b> Min. <b></b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farming</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Farm</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Boone Co. Missouri</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>	
<b>13a. FATHER'S NAME</b> <b>Thomas J. Asbury</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Susan Batton</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Roxie Blaise</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, No or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>499-28-1761</b>	<b>17. INFORMANT</b> Address <b>Mrs Henry O. Asbury Higbee, Mo</b>			

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Atherosclerosis - mild</u> DUE TO (c) <u>Coronary insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
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 type="checkbox"/> No <input type="checkbox"/> Unknown	

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour <b></b> a.m. <b></b> p.m. Month, Day, Year <b></b>	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
<b>21. I attended the deceased from</b> <u>1958</u> to <u>Oct 6, 59</u> and last saw <u>alive</u> on <u>Oct 5, 1959</u> Death occurred at <u>12:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22a. SIGNATURE</b> (Degree or title) <u>M. P. Reed M.D.</u>			<b>22b. ADDRESS</b> <u>Fayette Mo</u>		<b>22c. DATE SIGNED</b> <u>10-9-59</u>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE</b> <b>10/8/59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Fayette City Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Fayette, Missouri</b>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Kalsh A. Carr Fayette, Mo</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>10-9-59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Katherine Welch</u>		

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

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**STATEMENT BY LICENSED EMBALMER**

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

~~\_\_\_\_\_~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Ralph A. Carr*

Licensed Embalmer No. 334

P. O. Address Lafayette

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

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