

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-009883

STATE FILE NUMBER

AMENDED

Registration District No. 239 Primary Registration District No. 4356 Registrar's No. 7
FILED APR 3 1961

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Parma</u>		c. CITY OR TOWN <u>Parma</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Length of stay in lb <u>16 yrs</u>		Inside Limits Yes ☐ No ☐	
3. NAME OF DECEASED (Type or print) First <u>Oda</u> Middle <u>Mae</u> Last <u>Asher</u>		4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>cauc.</u>	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH <u>July 14, 1892</u>
9. AGE (last birthday) <u>68 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <u>Doniphan Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William Woolard</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Jones</u>	
14. NAME OF HUSBAND OR WIFE <u>James J. 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>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>James J. Asher</u> Address <u>Parma, Mo.</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>Cardiac decompensation</u>		INTERVAL BETWEEN ONSET AND DEATH	
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)		PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown	
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 <u>2:50</u> a.m. p.m. Month, Day, Year <u>7-31-1959</u>	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 <u>Parma, Mo.</u>	
20g. COUNTY <u>Malden</u>		20h. STATE <u>Missouri</u>	
21. I attended the deceased from <u>7-31-1959</u> to <u>March 11, 1961</u> and last saw her alive on <u>March 10, 1961</u> . Death occurred at <u>2:50 A:M</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. Geo. W. Hunted, M.D.</u>		22b. ADDRESS <u>Parma, Mo.</u>	
22c. DATE SIGNED <u>3/14/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Mar. 13, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park,</u>		23d. LOCATION (City, town, or county) <u>Malden, Missouri.</u>	
24. FUNERAL DIRECTOR <u>Watkins And Sons, Parma, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3/14/61</u>	
26. REGISTRAR'S SIGNATURE <u>Dr. Geo. W. Hunted, M.D.</u>			

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 Earl M. H. H.

Licensed Embalmer No. 4964

P. O. Address De Kalb Co

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.