

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020046

STATE FILE NUMBER

AMENDED

Registration District No. 325 Primary Registration District No. 44 26 Registrar's No. 4
FILED JUN 9 1961

1. PLACE OF DEATH a. COUNTY <u>Schuyler</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Schuyler</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Downing</u>		Length of stay in 1b <u>20 yrs.</u>		c. CITY OR TOWN <u>Downing</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Opal Curtis Residence</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Freddie Anderson Ashford</u>				4. DATE OF DEATH Month Day Year <u>June 4, 1961</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>7-27-82</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>7</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>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Downing, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Ashford</u>			13b. MOTHER'S MAIDEN NAME <u>Marilla Ashford</u>			14. NAME OF HUSBAND OR WIFE <u>Florence Ashford</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>498-03-3638</u>		17. INFORMANT Address <u>Opal Curtis, Downing, 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 arrest</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Consecutive heart failure</u> DUE TO (c) <u>Coronary heart disease</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							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>year</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 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 <u>12-3-58</u> to <u>6-4-61</u> and last saw her alive on <u>6-3-61</u> Death occurred at <u>6:30</u> A. M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>N.R. Sten</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>Lancaster, Mo.</u>		22c. DATE SIGNED <u>6-5-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>June 6, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Downing Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Downing, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Moore Funeral Home, Downing, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>June 5, 1961</u>		26. REGISTRAR'S SIGNATURE <u>Florence Shepherd</u>	

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Neal Payne

Licensed Embalmer No. 2550

P. O. Address Memphis, Tenn.

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.