

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-030824

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4174

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 4 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)	
a. COUNTY Jackson	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City	a. STATE MO b. COUNTY Johnson	c. CITY OR TOWN Prairie Village Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Saint Mary's Hospital		d. STREET ADDRESS (If outside, give location) 4306 W. 77th Terrace	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First Fern Middle G. Last Ashmore	4. DATE OF DEATH	Month August Day 18 Year 1962
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5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-24-1906	9. AGE (last birthday) 56 Yrs	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) At Home	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Laurens Iowa	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME George W. Strickland	13b. MOTHER'S MAIDEN NAME Effie Ann Warne	14. NAME OF HUSBAND OR WIFE Charles R. Ashmore
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. -	17. INFORMANT Charles R. Ashmore Address 4306 W. 77th Terr.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 4-6 hours
IMMEDIATE CAUSE (a) Cerebral Vascular Accident		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic Heart Disease Years	
	DUE TO (c) Pulmonary Emphysema Years	
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

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY	Hour 8:30 a.m. p.m.	Month, Day, Year 4-4-59
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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 Kansas City, Missouri
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21. I attended the deceased from **4-4-59** to **Current** and last saw her alive on **7-13-62**.
 Death occurred at **8:30** **A** m on the date stated above, and to the best of my knowledge, from the causes stated.

21. SIGNATURE Emery R. Calovich (Degree or title) MD	22b. ADDRESS 4620 J C Nichols	22c. DATE SIGNED 8/14/62
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-21-62	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah	23d. LOCATION (City, town, or county) Kansas City, Missouri
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24. FUNERAL DIRECTOR Stine & McClure ADDRESS Kansas City, Missouri	25. DATE RECD. BY LOCAL REG. 8-20-62	26. REGISTRAR'S SIGNATURE Ruth Long
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(Licensed Embalmer's Statement on Reverse Side)

VS 300
Rev. 4/59

1
2 **8150**
3
4 **1**
5 **1**
6
7 **1**
8 **0**
9 **4200**
10
11
12 **72-0**
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

EMERY R. CALOVICH

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

*Dr. Emory Belmont
P.O. Box Cherry Brook
D 0 1 - 9 2 5 8
will be there till
12:00 the 12.3.30*

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 *William M. Turner*

Licensed Embalmer No. *4648*

P. O. Address *Kansas City, Mo*

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.