

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-005859

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 100

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

FILED FEB 25 1963

1. PLACE OF DEATH a. COUNTY Dent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Missouri COUNTY Dent	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Salem		c. CITY OR TOWN Salem	
Length of stay in 1b 15 yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hart Hospital		d. STREET ADDRESS (If outside, give location) Henderson St	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Earnest Middle Asher Last		4. DATE OF DEATH Month Feb Day 22 Year 1963	
5. SEX male	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 7-30-82
9. AGE (last birthday) 80		IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) street car worker		10b. KIND OF BUSINESS OR INDUSTRY farming	
11. BIRTHPLACE (City and state or country) Dent Co Mo		12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME James Asher		13b. MOTHER'S MAIDEN NAME Martha Asher	
14. NAME OF HUSBAND OR WIFE Bertie Asher			
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. X	
17. INFORMANT Bertie Asher		Address Salem Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebrovascular Accident Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) GENERALIZED Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease 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 a few hrs
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 checked="" 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 8 1957 to Feb. 1963 and last saw him alive on 2/22/63 Death occurred at 8 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE B. J. Bass (Degree or title) MD		22b. ADDRESS Salem, Mo.	
22c. DATE SIGNED 2/23/63 (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 2-24-63	23c. NAME OF CEMETERY OR CREMATORY Cavenough Cem	23d. LOCATION (City, town, or county) Dent County Mo
24. FUNERAL DIRECTOR ADDRESS Spencer Funeral Home Inc		25. DATE RECD. BY LOCAL REG. 2-23-63	26. REGISTRAR'S SIGNATURE M. M. Hart, M.D. by A.M.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBONVS 300
Rev. 4/59

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

Student _____
Signature of Student Embalmer

Signed

W. R. D. Jones

Licensed Embalmer No.

2370

P. O. Address

Staten Island

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.