

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007747

STATE FILE NUMBER

Registration District No. 238 Primary Registration District No. 5823 Registrar's No. 13

FILED MAR 1 1963

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FURNERIAL DIRECTOR

USE BLACK INK OR TYPEWRITER RIBBON

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>Canalou</u>		c. CITY OR TOWN <u>Canalou</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION _____		d. STREET ADDRESS (If outside, give location) _____	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clara Elizabeth Asa</u>		4. DATE OF DEATH Month Day Year <u>Feb. 14, 1963</u>	
5. SEX <u>Female</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>Nov. 30, 1871</u>
9. AGE (last birthday) <u>91</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Wabash, Indiana</u>
12. IF UNDER 1 YEAR Months <u>2</u> Days <u>13</u>		13. IF UNDER 24 HR Hours _____ Min. _____	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Thomas Stucker</u>	
13b. MOTHER'S MAIDEN NAME <u>Jimimal Schykeit</u>		14. NAME OF HUSBAND OR WIFE <u>James Asa</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Christine Powell, Canalou, Mo</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senility</u>			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 checked="" type="checkbox"/>	20a. ACCIDENT. 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 _____ e.m. _____ p.m. _____	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>Aug. 23, 1948</u> to <u>Feb. 14, 1963</u> and last saw her <u>alive</u> on <u>Feb. 13, 1963</u> Death occurred at <u>1:00</u> <u>P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John P. Sargent, M.D.</u>		22b. ADDRESS <u>808 East Wakefield Sikeston Missouri</u>	22c. DATE SIGNED <u>2-23-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 16, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Mailey Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Mailey, Missouri</u>
24. FUNERAL DIRECTOR <u>Whittier Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>2-23-63</u>	26. REGISTRAR'S SIGNATURE <u>Fay Redgepath</u>
Sikeston, Mo (Licensed Embalmer's Statement on Reverse Side)			

MAR 1 1963

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

Raymond L. Duffer

Licensed Embalmer No. 4798

P. O. Address

Berme, 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.