

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

14985

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis* (No. *St. Lukes Hosp.*)

File No.

Register No. **3898**

St. Ward

2. FULL NAME *George T. Ashton*

(a) Residence. No. *8050 Liberty Ave. St.* *17* Ward. *St. Louis Co. Mo.*
(Usual place of abode) (if nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. If MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF *Lena M. Ashton.*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 19 - 1878*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	50	1	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Manager*
(b) General nature of industry, business, or establishment in which employed (or employer) *Morrison Hardware Co.*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Louis Missouri*
(STATE OR COUNTRY)

10. NAME OF FATHER *William Ashton*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *England*

12. MAIDEN NAME OF MOTHER *Mary Torrance*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Scotland*

14. INFORMANT *Mrs. Lena M. Ashton*
(Address) *8050 Liberty Ave.*

15. *APR - 9 1928* *May C. Barker* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 6 1928*

17. I HEREBY CERTIFY, That I attended/deceased from *3/27/28* 19 *28*
....., 19 *28* to *4/6* 19 *28*
that I last saw him alive on *7/10/27* 19 *27* and that death occurred, on the date stated above, at *4.20 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia, Lobar
Exacerbated, Lethargic

3 wks. (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) *influenza*
(duration) yrs. mos. *7* da.

18. WHERE WAS DISEASE CONTRACTED *W.C.*
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *G. H. Kram* M. D.
19 (Address) *3720 W. Washington*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Memorial Park Cem* DATE OF BURIAL *4-9 1928*

20. UNDERTAKER *Geo. L. Britsch* ADDRESS *5966 Eastern*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Benjamin 1814

3.30 A.M. 1813

8.30 at 5.00 3.00