

DEC 29 1930

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

Do not use this space.

38956

## PLACE OF DEATH

County Dekalb  
Township Washington  
City..... (No.....) St..... Ward.....

Registration District No. 258  
Primary Registration District No. 5360A

File No.....  
Registered No. 11  
St..... Ward.....

2. FULL NAME John Ashler

(a) Residence No..... St..... Ward.....  
(Usual place of abode) (If nonresident, give city or town and State)

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

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED  
HUSBAND OF  
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 17/53

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	<u>77</u>	<u>2</u>	<u>24</u>	

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN).....  
(STATE OR COUNTRY) Switzerland

10. NAME OF FATHER John Ashler

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

12. MAIDEN NAME OF MOTHER Not known

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

14. INFORMANT Mrs Chas Correll  
(Address) Clarksdale, Mo.

15. FILED 17/2 1930 C. M. Davis  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 11/30 19

17. I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1930, to Dec. 11, 1930, 19... that I last saw him alive on Dec. 11, 1930, and that death occurred, on the date stated above, at 3-p.m. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Indigestion, Acute

94 11 (duration) ..... yrs. .... mos. 1 ds.

CONTRIBUTORY Angina Pectoris  
(SECONDARY)

(duration) 3 yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTACTED

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? No... DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
(Signed) C. M. Davis, M. D.

12/12 1930 (Address) Clarksdale, Mo.

\*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  
Pleasant Grove Cemetery 12/13 1930

20. UNDERTAKER  
C. M. Davis, Clarksdale, Mo.

ADDRESS

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.

