

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

Do not use this space.

1. PLACE OF DEATH

County Cook
Township Beonville
City Beonville (No. _____)

Registration District No. 218
Primary Registration District No. 2013

24594
File No. _____
Registered No. 218
St. _____ Ward _____

2. FULL NAME

Mo. W. Ashborn (Edna Fern Morgan)
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W. J. Ashborn
6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 17 1912
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
19 1 16
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. INFORMANT

(Address)

15. FILED

7/6 1931

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 3 1931

17. I HEREBY CERTIFY, That I attended deceased from July 3 1931, to July 3 1931, that I last saw him alive on July 2nd 1931, and that death occurred, on the date stated above, at 3:30 AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Sepsis from Chronic 115A infectious glands in Neck, 101 Agonal septic Angina (2 attacks), 36
(duration) yrs. 9 mos. ds.

CONTRIBUTORY (SECONDARY)

Secondary Anemia + hemorrhage from mouth
(duration) yrs. 6 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DATE OF OPERATION PRECEDE DEATH? yes DATE OF June 20/31

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS clinical findings
(Signed) Walter M. W. W. M. D.

, 19 (Address) Beonville 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

DATE OF BURIAL

Corder Mo July 5 1931

20. UNDERTAKER

ADDRESS

Walter M. W. W. M. D. Beonville Mo.

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.

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

JUL 28 1931

