

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

727
Do not use this space.

791
1003

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No. **727**
 (c) City **St. Louis** (d) Street No. **240** **Missouri Pacific Hospital** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. **109 West Church St.**, St. **NR Morrilton, Ark.**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 **Katie Parker Ashley,**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **1868-8-10**

7. AGE YEARS **70** MONTHS **5** DAYS **13** IF LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Retired cashier**
 9. Industry or business in which work was done, as saw mill, bank, etc. **Mo. Pac. R. R.**
 10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Conway County, Ark.**

FATHER 13. NAME **Henry C. Ashley,**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Arkansas**

MOTHER 15. MAIDEN NAME **Katie Carroll**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Arkansas**

17. INFORMANT **Louise Ashley,**
(ADDRESS) **Morrilton, Ark.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Morrilton, Ark.** DATE **1/25/39** 19.....

19. FUNERAL DIRECTOR **Robert J. Ambruster**
(ADDRESS) **Clayton Rd. at Concordia Lane**

20. FILED **JAN 24 1939** **J. B. Budick**
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan 23**, 19**39**

22. I HEREBY CERTIFY, That I attended deceased from **Jan 10**, 19**39**, to **Jan 23**, 19**39**

I last saw him alive on **Jan 23**, 19**39** Death is said to have occurred on the date stated above, at **9 P. m.**

The principal cause of death and related causes of importance were as follows:

Coronary Occlusion
Chronic Myocarditis Date of onset

Other contributory causes of importance:
P.O. total laryngectomy (total) of larynx
Tracheotomy

Name of operation **laryngectomy (total)** Date of **5-14-38**
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? **No** Date of injury....., 19.....
 Where did injury occur?.....
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **No**
 If so, specify.....
 (Signed) **Henry J. Dink**, M. D.
 (Address) **W. P. C. Way**

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.

1 X12004

STATEMENT BY LICENSED EMBALMER

I, Edward H. Bockhorst, Licensed Embalmer No. 2502

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed

Edward H. Bockhorst

Licensed Embalmer No. 2502

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.)