

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.

19 1939

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

26767
Do not use this space.

REC'D AUG 7 1939

1. PLACE OF DEATH
 (a) County St. Louis Registration District No. 784
 (b) Township Central Primary Registration District No. 10
 (c) City Clayton (d) Street No. St. Louis County Hospital Registered No. 1306
 (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 Thomas A. Askey
 (a) Residence, No. 158 Argonne Drive Kerkwood St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 19-1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min. 2 hrs.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 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) St. Louis Co. Hospital Clayton Mo

FATHER

13. NAME William E. Askey
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Reber Mo

MOTHER

15. MAIDEN NAME Cleo Sheon
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Massouri

17. INFORMANT (ADDRESS) William E. Askey 158 W Argonne Drive Kerkwood

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Hill DATE July 20 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Louis H. Bopp Kerkwood Mo

20. FILED JUL 19 1939 DR. Keyes M. D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-19 1939

22. I HEREBY CERTIFY, That I attended deceased from 7-19-1939, 1939, to 7-19 1939, 1939
 I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at 3:40 p.m.
 The principal cause of death and related causes of importance were as follows:
Achondroplastic Dwarfism
157d
 Other contributory causes of importance:
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ 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? _____
 If so, specify _____
 (Signed) James Oland M. D.
 (Address) St. Louis County Hospital

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 3034

....., Registered Apprentice No.....

working under my personal supervision.

Signed Felix Durand

Licensed Embalmer No. 3034

P. O. Address Kirkwood 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 this body is not embalmed, above space should be left blank.