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.

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

42822
Do not use this space.

1. PLACE OF DEATH
(a) County Buchanan — Registration District No. 85
(b) Township — Primary Registration District No. 1001 — Registered No. 1300
or
(c) City St Joseph — (d) Street No. St Joseph's 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 216 (Infant) Dale Eugene Ashford
(a) Residence, No. 601 N. 13th St. (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): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 17th. 1939
7. AGE: YEARS 0 — MONTHS 0 — DAYS 0 — If LESS than 1 day, 0 hrs. or 0 min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant
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 Joseph Mo.

FATHER
13. NAME Everett Ashford
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Joseph Mo. C

MOTHER
15. MAIDEN NAME Melvie Stoker
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DeKalb Mo.

17. INFORMANT (ADDRESS) Mr. Everett Ashford 601 N. 13th. St. Joseph, Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Belmont Cemetery Wathena, Kan. DATE Dec. 18th. 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) FLEEMAN & SON, INC. 1946 Calhoun St. Joseph, Mo

20. FILED Dec 18, 1939 A. J. Nettlebush Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 17th. 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 17th 1939, to ..., 19..
I last saw h. 17 alive on Fresh alive — Born dead, 19.. Death is said to have occurred on the date stated above, at 7.30 A. m.
The principal cause of death and related causes of importance were as follows:

Still born Foetus due to intra uterine asphyxia due to strangulation of cord around baby neck twisted two times

Date of onset

Other contributory causes of importance: Thrombosis of umbilical cord

Name of operation none Date of
What test confirmed diagnosis? Phy. Exam Was there an autopsy? NO

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 none
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? NO
If so, specify
(Signed) [signature], M. D.
85 (Address) 825 Charles St Joseph Mo.

(Licensed Embalmer's Statement on Reverse Side)

## 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.....

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

working under my personal supervision.

Signed C G Swan

Licensed Embalmer No. 4082

P. O. Address St Joseph

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**