DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5508

Registration District No. FILED MAR 11 1940 399

Primary Registration District No. 1002

Registrar's No. 733

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K. C. Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks (Specify whether years, months or days)

In this community --

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates

(c) City or town Rural (If outside city or town limits, write "RURAL")

(d) Street No. Adrian R. F. D. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Oscar Askew

3. (b) If veteran, name war --

3. (c) Social Security No. --

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife --

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased May (Month) 22 (Day) 1860 (Year)

8. AGE: Years 79 Months 8 Days 27 If less than one day ..... hr. ..... min.

9. Birthplace Logan County (City, town, or county) Kentucky (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Robert W. Askew
13. Birthplace Not Known (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lucelia Carr
15. Birthplace (City, town, or county) North Carolina (State or foreign country)

16. (a) Informant's own signature Boone Askew

(b) Address Adrian Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-40 (Month) (Day) (Year)

(c) Place: burial or cremation Adrian Mo.

18. (a) Signature of funeral director Creath and Six

(b) Address Adrian Mo.

19. (a) Feb. 19, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 19-40 year ..... hour 4 minute 30 P M.

21. I hereby certify that I attended the deceased from 1-26-40, 19..., to 2-19-40, 19...; that I last saw him alive on 2-19-40, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Confluent Bronchopneumonia	
Due to Carcinoma of Sigmoid Colon	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations None	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Russell W. Kerr (M. D. or other)

Address KCMo Date signed

(Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

V. S. No. 2. 50M-5-17-39 Rev. 5-17-39 1 X19511

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.....

Licensed Embalmer No. 3650

P. O. Address Adrian Mich.

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.