

**FILED MAR 11 1940**  
**85**

Registration District No. \_\_\_\_\_ Primary Registration District No. **1001**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Missouri Methodist Hospital  
(If not in hospital or institution, write street, number or location)  
(d) Length of stay: In hospital or institution 1 day  
In this community Yes (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits write "RURAL")  
(d) Street No. 2217 Jones  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Asa Allen Breckenridge

8. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nelle W. Breckenridge 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased April 29, 1887  
(Month) (Day) (Year)

8. AGE: Years 52 Months 10 Days 0 If less than one day hr. \_\_\_\_\_ min.

9. Birthplace Troy Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Resturant operator

11. Industry or business Own Business

MOTHER FATHER { 12. Name James Breckenridge

13. Birthplace Unknown Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name Amanda Young

15. Birthplace Unknown Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant James Breckenridge

(b) Address 4452 No. 17th St. St. Joseph Mo.

17. (a) Removal (b) Date thereof Mar. 3, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Savannah Mo.

18. (a) Signature of funeral director Herman W. S. S. S.

(b) Address 1802 Union Str. St. Joseph Mo.

19. (a) 3/2/40 (b) H. J. Westphal  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month February day 29  
year 1940 hour 10 minute 30 A. M.

21. I hereby certify that I attended the deceased from Feb. 28  
1940 to Feb. 29 1940  
that I last saw him alive on Feb. 29 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage Feb. 28/40

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no

(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?  
\_\_\_\_\_

While at \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Frank J. S. S. (M. D. or other) \_\_\_\_\_

Address Templeton Bldg Date signed 3/2/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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

*Robert B. Harrington*

Licensed Embalmer No. 3258

P. O. Address St. Joseph, 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.**