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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 13 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

30336

State File No.

Registration District No. [redacted] Primary Registration District No. 2000 Registrar's No. 655

1. PLACE OF DEATH:
(a) County: GREENE
(b) City or town: SPRINGFIELD
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 534 E. HARRISON 1 ST
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Greene 38 2 6
(c) City or town: Springfield (If outside city or town limits, write "RURAL")
(d) Street No.: 534 E. Harrison (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: ELLA ASHWORTH.

3. (b) If veteran, name war: NONE

3. (c) Social Security No.: NONE

4. Sex: FEMALE

5. Color or race: WHITE

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

6. (b) Name of husband or wife: None

6. (c) Age of husband or wife if alive: [redacted] XX years

7. Birth date of deceased: March (Month) 30 (Day) 1857 (Year)

8. AGE: Years 185 Months 5 Days 9 If less than one day hr. min.

9. Birthplace: BOONVILLE (City, town or county) INDIANA (State or foreign country)

10. Usual occupation: House Work

11. Industry or business: In home

MOTHER FATHER

12. Name: John M. Ashworth

13. Birthplace: Evansville (City, town or county) Indiana (State or foreign country)

14. Maiden name: Mary Ann Cannon

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

16. (a) Informant: Alice Ashworth
(b) Address: 534 E. Harrison Springfield Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 11 1942 (Month) (Day) (Year)
(c) Place: burial or cremation: Maple Park Cemetery

18. (a) Signature of funeral director: J. W. Klingner
(b) Address: Springfield Mo.

19. (a) 9-11-42 (Date received local registrar) (b) W. S. Hundley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month: Sep. day: 9th year: 1942 hour: 11 minute: 55 A.M.

21. I hereby certify that I attended the deceased from June, 1937, to Sept 9, 1942, that I last saw her alive on Sept 7, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death: Uraemic Coma

Due to: Hypertension & Cardiac Fibrillation

Due to: Pus in Kidney

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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: [illegible] (M. D. or other)
Address: Kellogg Bl. Springfield Date signed 9/9/42

(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.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.

N No. 2B
M—8-21-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30336

Registration District No. 124 Primary Registration District No. 2000 Registrar's No. 655

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

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Ella Ashworth
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Mar (Month) 30 (Day) 1857 (Year)
8. AGE: Years 85 Months 5 Days If less than one day hr. min.
9. Birthplace: Ind (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. Day
year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremic Coma	
Due to: Hypertension	
Cardiac Fibrillation	
Due to: Pyuria - Kidney	
Chronic pyelonephritis Right	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: 133a
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY