No. 2
1-4-41
7-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 30 1943

Registration District No. 916

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

2206

State File No.

Primary Registration District No. 2000

Registrar's No. 12

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: O'Reilly General 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 1 yr., 6 mos., 25 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. 226 E. Kearney
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME LARRY PAUL ASBURY

3. (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 Sgl.

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

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

7. Birth date of deceased June (Month) 11, (Day) 1941 (Year)

8. AGE: Years	Months	Days	If less than one day
✓ 1	6	25	hr. min.

9. Birthplace Springfield, (City, town, or county) Missouri (State or foreign country)

10. Usual occupation - - Sgl

11. Industry or business - -

FATHER
12. Name William H. Asbury
13. Birthplace Unknown (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Joan Willingham
15. Birthplace Bristow (City, town, or county) Oklahoma (State or foreign country)

16. (a) Informant Mrs. Joan Asbury
(b) Address 226 E.Kearney, Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Springfield, Missouri

18. (a) Signature of funeral director J.E. Klingner & Co
(b) Address Springfield, Mo.

19. (a) 1-8-43 (Date received local registrar) (b) Dr. M.S. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 6 year 1943 hour 9 minute 25 A.M.

21. I hereby certify that I attended the deceased from January 5, 1943 to January 6, 1943 that I last saw him alive on January 6, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, broncho, bilateral — Duration 6 days

Due to N. M. O.

Due to

Other conditions (Include pregnancy within 3 months of death) 107

Major findings:
Of operations

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 [illegible] (M. D. or other)
Address [illegible] Date signed 1-6-43

484 (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 Roy A. Lacin

Licensed Embalmer No. 1763

P. O. Address Springfield Mo

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

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

No. 2B
M—8-21-41
P I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2206

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 12

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: O'Reilly Gen. Hosp.
(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: Larry Paul Asbury
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: S
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: June (Month) 11 (Day) 1919 (Year)

8. AGE: Years 1 Months 6 Days ..... If less than one day ..... hr. ..... min.

9. Birthplace: (City, town, or county) ..... Mo (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 ..... Day ..... year 1943 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... to ..... 19..... ; that I last saw him alive on ..... 19..... ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia Bronchi, bilateral	
Due to:	
Due to: No complications	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: 107	
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: Joseph H. Dick Capt. (M. D. or other)
Address: APO 708 c/o Postmaster San Francisco Calif. Date signed .....

SUPPLEMENTARY