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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 13 1943

Registration District No. 147

Primary Registration District No. 5569

Registrar's No. 123

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
67th & Bristol Avenue
(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 18 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson 0

(c) City or town Kansas City 0
(If outside city or town limits, write "RURAL")

(d) Street No. 67 & Bristol Avenue
(If rural, give location)

(e) Citizen of foreign country? _____ Yes _____ No _____
(Yes or No)
If yes, name country Holland 0

3. (a) PRINT FULL NAME Mr. Willem Asjes

3. (b) If veteran, name war No

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 Mrs. Catherina Asjes

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased February 22 1885
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>58</u>	<u>4</u>	<u>1</u>	hr. _____ min.

9. Birthplace Holland 4
(City, town, or county) (State or foreign country)

10. Usual occupation Gardener

11. Industry or business _____

MOTHER FATHER { 12. Name Barend Asjes

{ 13. Birthplace Velsen Holland 4
(City, town, or county) (State or foreign country)

{ 14. Maiden name Catherina Gappendaal

{ 15. Birthplace Holland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Catherina Asjes

(b) Address 67th & Bristol

17. (a) Burial (b) Date thereof June 26, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) June 25 1943 (b) Mrs. A. P. Sarvin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 23
year 1943 hour 7 minute 10 P. M.

21. I hereby certify that I attended the deceased from May 9
1943, to June 23 1943;
that I last saw him alive on June 23 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of stomach
metastasis to liver

Due to metastasis to liver

Due to _____

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

Major findings: 468
Of operations _____

Of autopsy Carcinoma of stomach with metastasis to liver

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? _____

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature E. H. Kelly (M. D. or other) _____

Address 402 Wabasha Date signed 6.24

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

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 Emile W. Calhoun

Licensed Embalmer No. 3506

P. O. Address KC 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, fact should be so stated above.

Registration District No. 147

Primary Registration District No. 222

Registrar's No. 123

1. PLACE OF DEATH

(a) County Jackson
(b) City or town RURAL-BROOKING TWP
(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
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME M. Wm Asjes

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 m

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

7. Birth date of deceased Feb. 22 1908
(Month) (Day) (Year)

8. AGE: Years 0-8 Months 4 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 12 Year 1943 Minute _____ M. _____

21. I hereby certify that I attended the deceased from _____ 19____;
that I saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

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

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

S-20117