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5-17-39  
X32873

38190

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED NOV 19 1946

Registration District No. 317

Primary Registration District No. 6876

Registrar's No. 3286

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
3191 Ashby Road.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Overland 14  
(If outside city or town limits, write "RURAL")

(d) Street No. 3191 Ashby Avenue.  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William F. Asmus.

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 Married

6. (b) Name of husband or wife Addie Asmus.

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased July 25, 1880.  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>3</u>	<u>14</u>	_____hr. _____min.

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

10. Usual occupation retired Salesman.

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William Asmus.

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

14. Maiden name Katherine Stein.

15. Birthplace St. Louis Co. Missouri.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Addie Asmus.

(b) Address 3191 Ashby Road.

17. (a) Burial (b) Date thereof 11-11-1946.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fee Fee Cemetery.

18. (a) Signature of funeral director Geo. L. Pleitsch, Inc.

(b) Address 5966-68 Easton Avenue.

19. (a) 11-13-46 (b) W. G. Allen  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 8th.  
year 1946 hour 9 minute 15 P.M.

21. I hereby certify that I attended the deceased from Feb 5 -  
1946 to 11-8 1946;  
that I last saw him alive on 11-8 1946;  
and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Pneumonia Duration 2 days

Due to Chronic Myocarditis 93 years.

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

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy NO

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 fall

23. Signature Ray A. Kallender (M. D. or other)

Address 2438 Woodman Rd. Overland. Date signed 11-9-46

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

37003

Dr. R. A. Walther.  
2438 Woodson Road.  
Winfield 0256  
Hours 2-4 & 7-8 P.M.

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**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.....

*John Keto*

Licensed Embalmer No.....

3880

P. O. Address.....

**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.