

U.S. No. 300  
FORM-10-47  
Rev. 5-17-39  
I 3906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED MAY 15 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 12397  
1919  
Registrar's No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

48  
2  
8

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

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:  
TRINITY LUTHERAN HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 DAY (Specify whether)

In this community 6 YEARS  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

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

(d) Street No. 1419 WEST 47TH STREET  
(If rural, give location)

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

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

3. (a) PRINT FULL NAME MR. WINHAM WALTER ASBURY

3. (b) If veteran, name war No

3. (c) Social Security No. 551-16-0721

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 3<sup>RD</sup>  
year 1948 hour 4 minute 05 P. M.

21. I hereby certify that I attended the deceased from May  
2, 1948, to 5-30, 1948.

that I last saw him alive on 5-3, 1948  
and that death occurred on the date and hour stated above.

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

(b) Name of husband or wife MRS. DOLLIE ASBURY

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased MAY 28 1890  
(Month) (Day) (Year)

Immediate cause of death  
Pneumonia  
Bilateral

Duration 5 wks

8. AGE: Years Months Days If less than one day

57 11 5 hr. min.

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

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

Other conditions Pericarditis  
(Include separately within 3 months of death)  
Pleural fibrosis

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

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

10. Usual occupation LABORER

11. Industry or business NATIONAL MFG. COFF. INS.

Of autopsy as above

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name JOSEPH ASBURY

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

14. Maiden name SARAH ROBINSON

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

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? \_\_\_\_\_

16. (a) Informant MRS. DOLLIE W. ASBURY

(b) Address 1419 WEST 47TH STREET

17. (a) BURIAL (b) Date thereof MAY 4 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation DENVER, ARKANSAS

18. (a) Signature of funeral director O. W. McComber, Inc.

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 5-4-48 (b) Margaret Holme  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature J. J. Thompson (M. D. or other)

Address 1103 Grand Date signed 5/4/48

R. E. M. U.

738 Professional Bldg  
2.4.38

200

110 b  
90 b

**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 Ray*

Licensed Embalmer No. 4182

P. O. Address Kansas City, 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.**