

FILED MAY 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 13559

Registrar's No. 3665

|  |  |  |                          |   |   |  |   |   |  |   |  |
|--|--|--|--------------------------|---|---|--|---|---|--|---|--|
| BIRTH NO. <u>318</u>   |  | REG. DIST. NO. <u>1003-318</u>   |                          | PRIMARY REG. DIST. NO. <u>1003</u>  |   | State File No. <u>13559</u>  |   | Registrar's No. <u>3665</u>                   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY   |  |  |                          | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Kentucky</u> b. COUNTY <u>Ballard</u> |   |  |   |   |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>ST. LOUIS</u>  |  |  |                          | c. LENGTH OF STAY (In this place)   |   | c. CITY (If outside corporate limits, write RURAL and give township) <u>Barlow</u> |   |   |  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Barnes Hospital</u>   |  |  |                          | d. STREET ADDRESS (If rural, give location) <u>2</u>  |   |  |   |   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print)   |  |  | a. (First) <u>GEORGE</u> |   |   | b. (Middle) <u>THOMAS</u>  |   |   | c. (Last) <u>ASHBY</u>                     |   |  |
| 4. DATE OF DEATH   |  |  | (Month) <u>APRIL</u>     |   |   | (Day) <u>22</u>  |   |   | (Year) <u>1949</u>                         |   |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>  |                          | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>   |   | 8. DATE OF BIRTH   |   | 9. AGE (In years last birthday) <u>71</u>     |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>  |  |  |                          | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>  |   | 11. BIRTHPLACE (State or foreign country) <u>Ashyburg, Kentucky</u>                |   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |   |  |
| 13a. FATHER'S NAME <u>J. W. Ashby</u>  |  |  |                          | 13b. MOTHER'S MAIDEN NAME <u>Beatrice Washington</u>  |   |  |   | 14. NAME OF HUSBAND OR WIFE <u>Ella Ashby</u> |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  |  |                          | 16. SOCIAL SECURITY NO. <u>Nil</u>  |   | 17. INFORMANT'S SIGNATURE OR NAME <u>A. C. Ashby - Evansville, Indiana</u>         |   | ADDRESS                                       |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  |  | MEDICAL CERTIFICATION  |                          |   |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>  |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of anus</u>  |  | ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |                          |   |   |  |   |   |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION   |                          |   |   |  |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)   |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                          |   | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |  |   |   |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                          |   | 21f. HOW DID INJURY OCCUR?                      |  |   |   |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>March 16, 1949</u> to <u>April 22, 1949</u> , that I last saw the deceased alive on <u>April 22, 1949</u> , and that death occurred at <u>6:15 p. m.</u> , from the causes and on the date stated above. |  |  |                          |   |   |  |   |   |  |   |  |
| 23a. SIGNATURE (Degree or title) <u>Chas. Barber Mueller M.D. U</u>  |  |  |                          |   |   | 23b. ADDRESS <u>Barnes Hospital</u>  |   |   | 23c. DATE SIGNED <u>4-22-49</u>            |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>   |  | 24b. DATE <u>4/23/49</u>   |                          | 24c. NAME OF CEMETERY OR CREMATORY  |   |  | 24d. LOCATION (City, town, or county) (State) <u>Barlow, Kentucky</u> |   |  |   |  |
| DATE REC'D BY LOCAL REG. <u>APR 21 1949</u>  |  | REGISTRAR'S SIGNATURE <u>J. B. Lasater</u>   |                          |   |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe-4700 Washington</u>    |   |   |  |   |  |

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10-48

17  
9

R.

7 Mil

---

---

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Clement McNeary

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3732

P. O. Address St. Louis

**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.