

FILED SEP 22 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29568

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

BIRTH NO. _____		REG. DIST. NO. <u>55</u>		PRIMARY REG. DIST. NO. <u>3011</u>		Registrar's No. <u>85</u>		
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE <u>Missouri</u> COUNTY <u>Carroll</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carrollton</u>		c. LENGTH OF STAY (In this place) <u>Life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carrollton</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) <u>215 Ford St.</u>				
3. NAME OF DECEASED (Type or Print) <u>Sarah Francis White Ashford</u>			a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 8, 1949</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>October 23, 1853</u>		9. AGE (In years last birthday) <u>95</u>	IF UNDER 1 YEAR (Months) <u>10</u>	IF UNDER 24 HRS. (Days) (Hours) (Min.) <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Warren County, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>John Randolph White</u>		13b. MOTHER'S MAIDEN NAME <u>Ann Rebecca Kenner</u>		14. NAME OF HUSBAND OR WIFE <u>John A. J. Ashford</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Chas. Newkham Carrollton.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
				ANTECEDENT CAUSES Aforbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____				
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>332X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input 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) _____		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>Sept. 5, 1949</u> , to <u>Sept 8, 1949</u> , that I last saw the deceased alive on <u>Sept. 5, 1949</u> , and that death occurred at <u>5:30</u> m., from the causes and on the date stated above.								
23a. SIGNATURE <u>Jim H. Platy M.D.</u>				23b. ADDRESS <u>Carrollton Missouri</u>		23c. DATE SIGNED <u>9-9-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9/10/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Carrollton, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>9/9/49</u>		REGISTRAR'S SIGNATURE <u>Miss Rebecca Calvert</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Marshall Funeral Home Carrollton</u>				

RECEIVED SEP 12

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 9-21-49

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.

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

Signed A. M. Marshall Jr

Licensed Embalmer No. 4469

P. O. Address Carrollton, Ga

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.