

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 31 1950

State File No. **8209**
Registrar's No. **12**

BIRTH NO. _____ REG. DIST. NO. **114** PRIMARY REG. DIST. NO. **486**

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY CRAWFORD	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SULLIVAN, MO		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SULLIVAN, MO	
c. LENGTH OF STAY (If in this place) 1 HR.		d. STREET ADDRESS (If rural, give location) 3215. OLIVE	
d. FULL NAME OF HOSPITAL OR INSTITUTION NORTHSIDE HOSP.			
3. NAME OF DECEASED a. (First) KENNETH b. (Middle) LEON c. (Last) ASH		4. DATE OF DEATH (Month) (Day) (Year) MARCH 24 1950	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) CHILD	8. DATE OF BIRTH MAY 2 1946
9. AGE (In years last birthday) 3		10. MONTHS 10	11. DAYS 22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) SULLIVAN, MO
12. CITIZEN OF WHAT COUNTRY? U.S.A			
13a. FATHER'S NAME GEORGE WASHINGTON ASH		13b. MOTHER'S MAIDEN NAME ELSIE MARIE PARKER	
14. NAME OF HUSBAND OR WIFE Rungle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME Clarence Parker		ADDRESS Waynesville, Mo.	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Laryngo tracheo bronchitis INTERVAL BETWEEN ONSET AND DEATH 48 HRS. ANTECEDENT CAUSES Morbidity 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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 3/23, 1950 , to 3/24, 1950 , that I last saw the deceased alive on 3/24, 1950 , and that death occurred at 3:00 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Dress or title) John J. de Laine M.D.		23b. ADDRESS Sullivan, Mo	
23c. DATE SIGNED 3/24/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/26/50	
24c. NAME OF CEMETERY OR CREMATORY Sanders Graveyard		24d. LOCATION (City, town, or county) (State) Waynesville, Mo.	
DATE REC'D BY LOCAL REG. 3-25-1950		REGISTRAR'S SIGNATURE Clarence Parker	
25. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Havelton		ADDRESS Sullivan, Mo.	

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

036j

District Health Officer No. 9
District File Number

RECEIVED
MAR 27 1950

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 Edgar W. Talboon
Licensed Embalmer No. 3394

P. O. Address Sullivan 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.