

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41422

State File No. ....

FILED JAN 15 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. 87

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>0750</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ALTON - RURAL</u>	
c. LENGTH OF STAY (in this place) <u>4 days</u>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>CHRIST. HOGAN HOSPITAL</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Asberry</u> b. (Middle) <u>E.</u> c. (Last) <u>ANDREW'S</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 4 '51</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, NEVER MARRIED, WIDOWED (Specify) <u>MARRIED</u>	
8. DATE OF BIRTH <u>10-18-1864</u>		9. AGE (In years last birthday) <u>87</u>		IF UNDER 1 YEAR: Months <u>0</u> Days <u>16</u> IF UNDER 100 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					

13a. FATHER'S NAME <u>Christopher Andrews</u>		13b. MOTHER'S MAIDEN NAME <u>JASTON (UNKNOWN) ANDREWS</u>		14. NAME OF HUSBAND OR WIFE <u>MARY ANDREWS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Christi Hogan Hospital West Plains, Mo.</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, ashenia, 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> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>10 yrs</u>	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>332 X</u>		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) <u>11-1-51</u> 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 11-1-1951, to 11-4-1951, that I last saw the deceased alive on 11-4-1951, and that death occurred at 6:25 P m., from the causes and on the date stated above.

23d. SIGNATURE <u>Dr. Callahan M.D.</u> (Degree or Title)		23b. ADDRESS <u>West Plains, Mo</u>		23c. DATE SIGNED <u>11/24/51</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>11-8-1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Shubb Cemetary</u>		24d. LOCATION (City, town, or county) (State) <u>Alton Mo.</u>	
DATE REC'D BY LOCAL REG. <u>1-11-52</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u> 379		25. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Cary</u>		ADDRESS <u>Alton Mo.</u>	

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

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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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....  
Student Embalmer

Signed

*John G. Clary*

Licensed Embalmer No. *4475*

P. O. Address *Box 398, Altamont, N.J.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.