

FILED SEP 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31610

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8357**

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Indiana b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN ST. LOUIS, MISSOURI | | c. LENGTH OF STAY (in this place) | c. CITY OR TOWN Cass |
| d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL | | f. STREET ADDRESS (If rural, give location) 812 9 | |

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|-------------------------------------|-----------------------|--------------------------|------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) ORA | b. (Middle) (NMI) | c. (Last) ASHBY | 4. DATE OF DEATH (Month) (Day) (Year) SEPTEMBER 8, 1954 |
|-------------------------------------|-----------------------|--------------------------|------------------------|--|

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|----------------------|-------------------------------|--|-----------------------------------|---|-----------------------------|-----------------------------|
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced | 8. DATE OF BIRTH 2-23-1907 | 9. AGE (In years last birthday) 47 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
|----------------------|-------------------------------|--|-----------------------------------|---|-----------------------------|-----------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) school teacher | 10b. KIND OF BUSINESS OR INDUSTRY teaching | 11. BIRTHPLACE (City and State or Foreign Country) Kentucky | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME Joe Ashby | 13b. MOTHER'S MAIDEN NAME Tiney Anderson | 14. NAME OF HUSBAND OR WIFE unknown |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. none | 17. INFORMANT'S SIGNATURE OR NAME Fred Ashley, Flint, Michigan | ADDRESS |
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| 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. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suspected Brain Tumor | | INTERVAL BETWEEN ONSET AND DEATH 2 mo. |
| | ANTECEDENT CAUSES Morbid 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. | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 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) |
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| 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? |
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22. I hereby certify that I attended the deceased from **8-30-**, 19 **54**, to **9-8-**, 19 **54**, that I last saw the deceased alive on **9-8-**, 19 **54**, and that death occurred at **3:00 A.m.**, from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) Robert L. Donough M. D. | 23b. ADDRESS BARNES HOSPITAL | 23c. DATE SIGNED 9-8-54 |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) removal | 24b. DATE 9-9-54 | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) Pleasantville, Ind. |
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| DATE REC'D BY LOCAL REG. SEP 11 1954 | REGISTRAR'S SIGNATURE J. Carl Smith M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE Newkirk, Pleasantville, Ind. | ADDRESS |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No.....
P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.