

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031336

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2103

FILED AUG 28 1958

1000
300
4
1-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Robertson</u>		c. CITY OR TOWN <u>St. Louis</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>Carter Nursing</u> INSTITUTION <u>Home</u>		d. STREET ADDRESS (If outside, give location) <u>4928 Wabada Ave.</u>	
Length of stay in lb <u>4 mos. 20/69</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>DANIEL</u> Middle <u>LINDSAY</u> Last <u>ASHBY</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>9</u> Year <u>1958</u>		
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5. SEX <u>Male 2</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/26/1889</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>13</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Handler</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Post Office</u>	11. BIRTHPLACE (City and state or country) <u>Bedford, Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Daniel M. Ashby</u>	13b. MOTHER'S MAIDEN NAME <u>Josephine Copeland</u>	14. NAME OF HUSBAND OR WIFE <u>Goldie S. Ashby</u>
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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>499-34-4297</u>	17. INFORMANT <u>Goldie S. Ashby</u>	Address <u>4928 Wabada Avenue</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral arteriosclerosis.</u>	<u>unknown.</u>
	DUE TO (c) <u>332X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour . Month, Day, Year a.m. p.m.	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 5/57 to 8/2/58 and last saw her alive on 8/2/58
Death occurred at 9:25 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>A. G. Inman M.D.</u>	22b. ADDRESS <u>4901 A Easton.</u>	22c. DATE SIGNED <u>8/11/58.</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/13/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
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24. FUNERAL DIRECTOR <u>Charles J. Gates</u>	ADDRESS <u>4107 Finney</u>	25. DATE RECD. BY LOCAL REG. <u>8-12-58</u>	26. REGISTRAR'S SIGNATURE <u>Wesley R. Donke M.D.</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

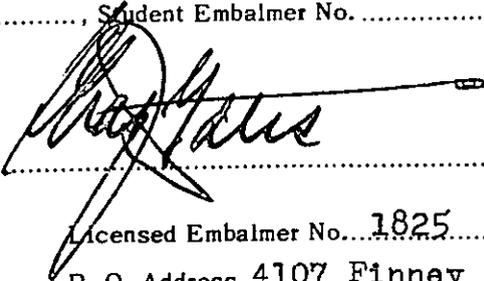
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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. 1825

P. O. Address 4107 Finney Aven

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.