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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-010671

STATE FILE NUMBER

MAR 30 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 2329

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis, Mo. Inside Limits Yes ☐ No ☐	c. CITY OR TOWN Pagedale 4291 Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) DePaul Hospital Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1345 Ferguson Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First: JOSEPH	Middle: MILTON	Last: ASBY	4. DATE OF DEATH Month Day Year: March 6, 1959
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: April 16, 1900	9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR Months 10 Days 20 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): General Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): Silex, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME: George Asby	13b. MOTHER'S MAIDEN NAME: Mary Koster	14. NAME OF HUSBAND OR WIFE: Viola Asby		
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.: 498-01-5331	17. INFORMANT: Viola Asby	Address: 1345 Ferguson Pagedale, Mo.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of left kidney

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) with metastases to the

DUE TO (c) liver and brain

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 180X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1/4/59, to 3/6/59 and last saw ~~her~~ him alive on 3/5/59

Death occurred at 12:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Robert Potashnick M.D.	22b. ADDRESS: 3720 Washington	22c. DATE SIGNED: 3/6/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: 3-6-1959	23c. NAME OF CEMETERY OR CREMATORY: Oak Grove Cemetery	23d. LOCATION (City, town, or county) (State): St. Charles, Missouri
24. FUNERAL DIRECTOR: J.O. Mudd	ADDRESS: Bowling Green, Missouri	25. DATE RECD. BY LOCAL REG.: MAR 6 '59	26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

Not embalmed.

Student .....
Signature of Student Embalmer

Signed Robert B. Peaker

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.