

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025449

FILED VS. JUN 20 1960 323

Primary Registration District No. 4474 Registrar's No. 22

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>SALINE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SALINE</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SWEET SPRINGS</u>		Length of stay in 1b <u>11 YEARS</u>		c. CITY OR TOWN <u>SWEET SPRINGS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>303 E MARSHALL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>303 E. MARSHALL</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>PASALAS</u> Middle <u>P.</u> Last <u>ASHURST</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</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>JULY 5, 1875</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GEN FARMING</u>		11. BIRTHPLACE (City and state or country) <u>GEORGETOWN KY.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ROBERT P. ASHURST</u>			13b. MOTHER'S MAIDEN NAME <u>VIRGINIA WARE</u>		14. NAME OF HUSBAND OR WIFE <u>U.S.A.</u>		
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>No</u>		17. INFORMANT <u>EARL C. ASHURST</u> Address <u>KANSAS CITY, MO.</u>		
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>Metastatic cerebral carcinoma</u> DUE TO (b) <u>Carcinoma of prostate</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>	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		
21. I attended the deceased from <u>Dec 1953</u> to <u>June 60</u> and last saw him alive on <u>6-14-60</u> Death occurred at <u>2:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>[Signature]</u>				22b. ADDRESS <u>Sweet Springs, Mo</u>		22c. DATE SIGNED <u>6-16-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6/18/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MACHPELAH</u>		23d. LOCATION (City, town, or county) (State) <u>LEXINGTON MO</u>			
24. FUNERAL DIRECTOR <u>PARKER FUNERAL HOME</u> ADDRESS <u>SWEET SPRINGS MO</u>			25. DATE RECD. BY LOCAL REG. <u>June 17, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mary Manly</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by me, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed E. S. James

Licensed Embalmer No. 2058

P. O. Address Concord

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.