

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-013479
STATE FILE NUMBER

AMENDED FILED MAY 1 1961
Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 50

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>		2. USUAL RESIDENCE (Where deceased lived, or institution; residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Harrison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany</u>		c. CITY OR TOWN <u>Bethany</u>	
Length of stay in 1b <u>20 yr</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>No</u>		d. STREET ADDRESS (If outside, give location) <u>409 S. 13th</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Johnathon</u> Last <u>Ashford</u>			4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1961</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>5-16-1891</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Bethany, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>George Ashford</u>		13b. MOTHER'S MAIDEN NAME <u>Barbara Ellis</u>		14. NAME OF HUSBAND OR WIFE <u>Grace</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>			17. INFORMANT <u>Grace Ashford</u> Address <u>Bethany Mo.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Peripheral vascular collapse</u>		<u>2 HOURS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Spontaneous intracerebral hemorrhage</u>	<u>12 HOURS</u>
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>Arteriosclerotic cardiovascular disease</u>		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	
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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>Oct '60</u> to <u>TIME OF DEATH</u> and last saw him alive on <u>4/22/61</u> Death: occurred at <u>5:20 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>J B Titmarsh M.D.</u> (Degree or title)	22b. ADDRESS <u>Bethany, Mo.</u>	22c. DATE SIGNED <u>7/25/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>4/25/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Miriam</u>
<u>Burial</u>		23d. LOCATION (City, town, or county) <u>Bethany Mo.</u> (State)

24. FUNERAL DIRECTOR <u>M B Haas</u> ADDRESS <u>Bethany Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4-25-1961</u>	26. REGISTRAR'S SIGNATURE <u>Zella Maxey</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

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 MBK has

Licensed Embalmer No. 3899

P. O. Address Bethany Mo.

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.