

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-027793

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 109 Primary Registration District No. 4180 Registrar's No. 27

FILED JUL 22 1963

VS 300
Rev. 4/59

1 0350

2 0356

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4 0

5 2

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7 1

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9 4200

10

11

12 86.0

13 7-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY DUNKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY DUNKLIN	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN CAMPBELL		Length of stay in 1b 5 Yrs.	c. CITY OR TOWN MALDEN
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION GEN. BAPTIST REST HOME		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) So. MARION ST.
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE ALEXANDER ASA		4. DATE OF DEATH Month Day Year JULY 15, 1963	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-23-1868
9. AGE (last birthday) 95		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) WAYNE CO. ILL.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME PRESTON ASA	
13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE DAISY M. ASA, (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT Address CHAS. P. ASA - INDIANAPOLIS, IND.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) _____ Conditions, if any, which gave rise to above cause (e), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 15 YEARS
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 a.m. p.m. Month, Day, Year		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>4-24-63</u> to <u>7-15-63</u> and last saw him alive on <u>7-14-63</u> Death occurred at <u>3:05 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Charles Williams, M.D.</i>		22b. ADDRESS MALDEN, MO.	
22c. DATE SIGNED 7-16-63		22d. LOCATION (City, town, or county) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 7/17/1963	23c. NAME OF CEMETERY OR CREMATORY DEXTER CITY CEMETERY	
23d. LOCATION (City, town, or county) DEXTER-STODDARD - MO.		24. FUNERAL DIRECTOR ADDRESS DAY & KNIGHT F.H. - MALDEN, MO.	
25. DATE RECD. BY LOCAL REG. 7-27-1963		26. REGISTRAR'S SIGNATURE <i>Walter Campbell</i>	

USE BLACK INK OR TYPEWRITER RIBBON

80-100-000

STATE OF MASSACHUSETTS

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 J. J. Kline

Licensed Embalmer No. 4086

P. O. Address Malden

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.