N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Ray

Township ____ or Village Orrick or City ____ (No. ____ St. ____ Ward)

Registration District No. 743 File No. 23941

Primary Registration District No. 4445 Registered No. ____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME William Jay Ashley

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widower

DATE OF BIRTH Sept 12, 1833 (Month) (Day) (Year)

AGE 83 yrs. 9 mos. 18 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) —

BIRTHPLACE (City or town, State or foreign country) Marion Ky.

PARENTS
- NAME OF FATHER Edward Ashley
- BIRTHPLACE OF FATHER (City or town, State or foreign country) S. C.
- MAIDEN NAME OF MOTHER Hulton
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T J Ashley

(ADDRESS) Orrick Mo

Filed July 1, 1917 L. E. Ellis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June (Month) 30 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 15, 1917, to June 30, 1917, that I last saw him alive on June 30, 1917, and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

97A

70

(Duration) ____ yrs. 5 mos. 15 ds.

Contributory (SECONDARY) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) T J Ashley M. D.

July 1, 1917 (Address) Orrick Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL Fords Chapel — DATE OF BURIAL July 1" 1917

UNDERTAKER Burgess & Hall — ADDRESS Orrick Mo

PLACE OF DEATH

County.....

Township ..... or Village ..... or City ..... (NO. ....., ... St.; ..... Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. ..... Primary Registration District No. .....

File No. .....

Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ....., 1..... (Day) (Year)

AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191..... (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS