

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

Do not use this space.

19771

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....

Registration District No. **791**  
Primary Registration District No. **1003**  
No. **St. Lukes Hosp**

File No.....  
Registered No. **5769**  
St..... Ward.....

**2. FULL NAME**

*Infant. Ainsworth*

(a) Residence. No..... St. **12** Ward. **Clayton Mo. V**  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. **30 7** mos. long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **boy**  
4. COLOR OR RACE **white**  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Single**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **5-11-1931**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **30 7**

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) **St. Louis Mo.**  
(STATE OR COUNTRY)

10. NAME OF FATHER **Wallace Ainsworth**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **St. Louis Mo.**  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Mary Anderson**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Ohio**  
(STATE OR COUNTRY)

14. INFORMANT **Walter Ainsworth**  
(Address) **Clayton Mo.**

15. FILED **21**, 19**31** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 11, 1931**

17. I HEREBY CERTIFY, That I attended deceased from **5-11-1931** to **5-11-1931** that I last saw him live on **5-11-1931** and that death occurred, on the date stated above, at **5 p.m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**congenital abnormality  
enlarged liver & ascites**

CONTRIBUTOR (SECONDARY) **1570**  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **1570**  
IF NOT AT PLACE OF DEATH.....  
(duration) yrs. mos. ds.

DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....  
WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS **Dr. A. Royston** M. D.  
(Signed).....  
, 19 (Address) **3720 Washington**

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Assigned as Specimen 5-11-1931**  
DATE OF BURIAL

20. UNDERTAKER **St. Lukes Hospital**  
ADDRESS

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

