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.

REC'D JUN 8 1939

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

17614
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson | Registration District No. 399
(b) Township Kaw | Primary Registration District No. 1002 | Registered No. 2016
(c) City Kansas City Mo (d) Street No. St Vincents Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 620 Miss Sally Ayers
(a) Residence, No. St. St Louis Mo
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female | 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) Dec 7 1912

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
26	5	8	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Clerk
9. Industry or business in which work was done, as saw mill, bank, etc. Famous Barrel
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

FATHER
13. NAME Duncan Ayers
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky

MOTHER
15. MAIDEN NAME Laura Hurley
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky

17. INFORMANT (ADDRESS) Mrs Leona Ayers 507 Shenandoah Ave

18. BURIAL, CREMATION, OR REMOVAL
PLACE St Louis DATE May 15 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. W. Wagner K.C. Mo

20. FILED May 15 1939 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 15, 1939

22. I HEREBY CERTIFY, That I attended deceased from 1/16/39, 19.., to 5/15/39, 19..
I last saw her alive on 5/15/39, 19.. Death is said to have occurred on the date stated above, at 9:49 a.m.
The principal cause of death and related causes of importance were as follows:

Obstetrical Shock
2 Hours duration
149 B.

Date of onset 5/15/39

Other contributory causes of importance:
none

Name of operation Mid Forceps Episiotomy Date of 5/15/39
What test confirmed diagnosis? Clinical. Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury ....., 19..
Where did injury occur? no
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. no
Manner of injury
Nature of injury no

24. Was disease or injury in any way related to occupation of deceased?
If so, specify no
(Signed) Joseph Mehler M. D.
(Address) 9125 Ayres Bldg.

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Registered Apprentice No....., working under my personal supervision.

Signed .....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.