No. 300
10-48

FILED NOV 4 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35849

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 4172

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gardenville
c. LENGTH OF STAY (in this place) 3 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Miller Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ? Gardenville
d. STREET ADDRESS (If rural, give location) Miller Nursing Home

3. NAME OF DECEASED (Type or Print)
a. (First) Marion
b. (Middle)
c. (Last) Ayers

4. DATE OF DEATH (Month) (Day) (Year) 10/17/49

5. SEX F
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W
8. DATE OF BIRTH Oct. 21, 1874
9. AGE (In years last birthday) 74 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN
10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN
11. BIRTHPLACE (State or foreign country) Rochester New York
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT'S SIGNATURE OR NAME Miss Black St. Louis Co. Welfare Board
ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Chronic Heart and Kidney Disease	2 Mo.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerosis	1 yr
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		4500

19a. DATE OF OPERATION no
19b. MAJOR FINDINGS OF OPERATION none 450.0
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 12th 1949 *to* Oct. 17, 1949, *that I last saw the deceased alive on* Oct. 15 1949 *and that death occurred at* 6:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE W. H. Walters M.D. (Degree or title)
23b. ADDRESS 3608 South Grand Blvd.
23c. DATE SIGNED 10/18/49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/18/49
24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cem.
24d. LOCATION (City, town, or county) Lemay Mo. (State)

DATE REC'D BY LOCAL REG. 10-18-49
REGISTRAR'S SIGNATURE Herbert R. Wonke M.D.
25. FUNERAL DIRECTOR'S SIGNATURE J. L. Ziegenhein & Sons
ADDRESS 7027 Gravois

(Licensed Embalmer's Statement on Reverse Side)

JUL 11 1959

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 .....
Student Embalmer

Signed Not Embalmed.

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.