

No. 300
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REG. FILED MAR 16 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11041

BIRTH NO. _____ REG. DIST. NO. 37 PRIMARY REG. DIST. NO. 6076 Registrar's No. 599

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS b. COUNTY ST. CLAIR	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JEFFERSON BARRACKS, MO.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN EAST ST. LOUIS	
c. LENGTH OF STAY (in this place) 80 DAYS		d. STREET ADDRESS (If rural, give location) 1111 No. 3RD ST.	
d. FULL NAME OF HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL			

3. NAME OF DECEASED (Type or Print) FRANK (First) (NMT) (Middle) AYRES (Last)			4. DATE OF DEATH (Month) (Day) (Year) 3-1-51		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 9-16-94	9. AGE (In years last birthday) 56	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY GRAIN CO.		11. BIRTHPLACE (State or foreign country) HOLLY SPRINGS, MISS.	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME FRANK AYRES		13b. MOTHER'S MAIDEN NAME MARY ANN JEFFRIES		14. NAME OF HUSBAND OR WIFE CLARA AYRES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-I		16. SOCIAL SECURITY NO. UNK.		17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) CARCINOMA OF PANCREAS		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH	

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

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 12-29-50		19b. MAJOR FINDINGS OF OPERATION CARCINOMA OF HEAD OF PANCREAS		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) 157X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **12-21**, 19**50**, to **3-1-51**, 19**51**, and that death occurred at **6:05 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE J. P. Paulbald (Degree or title) MD		23b. ADDRESS VA HOSPITAL, JEFF. BRKS., MO.		23c. DATE SIGNED 3-1-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE March 8, 1951		24c. NAME OF CEMETERY OR CREMATORY Jefferson Barracks	
24d. LOCATION (City, town, or county) (State) Jefferson Barracks Mo.		24e. FUNERAL DIRECTOR'S SIGNATURE C. J. Nash		24f. ADDRESS 3847 Page	
DATE REC'D BY LOCAL REG. 3/6/51		REGISTRAR'S SIGNATURE Hubert P. Lombardi		24g. FUNERAL DIRECTOR'S SIGNATURE C. J. Nash	

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

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

M. Frances Page

Licensed Embalmer No. *4434*

P. O. Address *3847 Page*

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