

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **20145**  
Registrar's No. **4942**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN) St. Louis		c. LENGTH OF STAY (in this place) 7-days	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Park Lane Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) Eltha b. (Middle) Irene c. (Last) Ayo		4. DATE OF DEATH (Month) (Day) (Year) June 2, 1954	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) D.	8. DATE OF BIRTH Jan. 11, 1888
9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Cherryville, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME James R. Wheeling	
14. MOTHER'S MAIDEN NAME Martha Jane Cole		15. NAME OF HUSBAND OR WIFE Loderia P. Ayo	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no.		17. SOCIAL SECURITY NO.	
18. INFORMANT'S SIGNATURE OR NAME Mr. Eugene L. Ayo		19. ADDRESS 4116 Westminster Place	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis An antecedent cause: Anemia 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. Operated 5-29-54 for Esophagogastric Hiatal Hernia		INTERVAL BETWEEN ONSET AND DEATH 1 year 1 yr	
19a. DATE OF OPERATION 3-29-54		19b. MAJOR FINDINGS OF OPERATION hiatal hernia, esophagogastric		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)	
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? 5604	

22. I hereby certify that I attended the deceased from Oct 1st, 1953, to 6-2-1954, that I last saw the deceased alive on 6-2-1954, and that death occurred at 6:08 Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Clayton B. Kane M.D.		23b. ADDRESS 706 Walton		23c. DATE SIGNED 6-3-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 5, 1954		24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.					

DATE REC'D BY LOCAL REG. JUN 4 1954		REGISTRAR'S SIGNATURE Carl Smith		GENERAL DIRECTOR'S SIGNATURE J. Donnelly		ADDRESS 10 Lindell Blvd.	
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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 me..... Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Wm S. Deffen.....

Licensed Embalmer No. 469.....

P. O. Address R. Char.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.