

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37132**

FILED NOV 1 1957

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 9814

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 9814				
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI				b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place) 49 YRS.		c. CITY OR TOWN ST. LOUIS		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION 27 Homer G. Phillips Hospital				STREET ADDRESS (If rural, give location) 1463 Goodfellow Ave.						
3. NAME OF DECEASED (Type or Print) a. (First) ALFRED			b. (Middle) D.			c. (Last) AYERS				
4. DATE OF DEATH (Month) (Day) (Year) Oct. 17 1957		5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH April 23, 1899		
9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months 5		IF UNDER 24 HRS. Days 24		Hours _____		Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (City and State or Foreign Country) Livermore, Kentucky			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Gip Ayers			13b. MOTHER'S MAIDEN NAME Eddie Mae Duncan			14. NAME OF HUSBAND OR WIFE _____				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) Yes W.W.#2		16. SOCIAL SECURITY NO. 191-12-5850		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Eddie Mae Haynes 1463 Goodfellow Ave.						
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) Cerebral Vascular Accident (Hemorrhage)						INTERVAL BETWEEN ONSET AND 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) 331X								
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.										
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 035A m., from the causes and on the date stated above.										
23a. SIGNATURE Deputy Registrar				23b. ADDRESS 1300 Clark				23c. DATE SIGNED 10/19/57		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Oct. 21, 1957		24c. NAME OF CEMETERY OR CREMATORY National		24d. LOCATION (City, town, or county) (State) Jefferson Barracks Mo.				
DATE REC'D BY LOCAL REG. OCT 21 1957		REGISTRAR'S SIGNATURE Carl Smith				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. H. RANDLE & SON 3133 BELL AVE.				

WRITE PLAINLY—USING UNEADING 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.....
Signature of Student Embalmer

Signed *Esther W. Harris*

Licensed Embalmer No. *4458*
P. O. Address *418 1/2 Washington*

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.