

FILED OCT 15 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH38862  
STATE FILE NUMBERRegistration District No. 337 Primary Registration District No. 4498 Registrar's No. 69

1. PLACE OF DEATH a. COUNTY <b>Shelby</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Shelby</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hunnewell</b>		c. CITY OR TOWN <b>Hunnewell</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Town Limits.</b>		Length of stay in 1b <b>15 Yrs.</b>	
d. STREET ADDRESS <b>Town Limits</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas Lee Ayers</b>			4. DATE OF DEATH Month <b>October</b> Day <b>8</b> , Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/9/1878</b>
9. AGE (In years - last birthday) <b>79</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>29</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	11. BIRTHPLACE (City and state or country) <b>Natural Bridge Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13a. FATHER'S NAME <b>John W. Ayers.</b>	
13b. MOTHER'S MAIDEN NAME <b>Virginia Gilbert</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Tom Ayers.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>492-28-1178</b>	17. INFORMANT <b>Mrs. Fred Scouten. Rock Island Ill.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>9 mos.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arterio-sclerosis</b>			<b>5 years</b>
DUE TO (c) <b>Hypertension</b>			<b>2</b>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a)) <b>4201</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>Jan 8, 1957</b> to <b>Oct 1, 1957</b> and last saw <sup>him</sup> alive on <b>Oct 1, 1957</b> Death occurred at <b>6:30 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Dr. J. H. Tomei D.O.</b>		(Degree or title)	22b. ADDRESS <b>Shelby Mo</b>
22c. DATE SIGNED <b>10/10/57</b>			
23a. BURIAL, CREMATION, or other disposition (Specify)	23b. DATE <b>10/10-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Hunnewell Missouri</b>
24. FUNERAL DIRECTOR <b>Harold Garner, Monroe City Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>10-10-57</b>	26. REGISTRAR'S SIGNATURE <b>Ada Garrison</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

S. 300  
1-571020  
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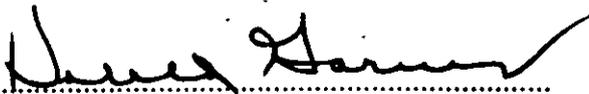
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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**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  .....

Licensed Embalmer No. 3720

P. O. Address Monroe City, Mo

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.