

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022652  
STATE FILE NUMBER  
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doctor, coroner, etc.; most use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

**JUN 19 1959**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kirkwood 4723</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>2215 Fern Cliff Lane</b>
3. NAME OF DECEASED (Type or print) First Middle Last <b>DOROTHY JOSEPHINE AYLESWORTH</b>		4. DATE OF DEATH Month Day Year <b>MAY 27, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 9, 1903</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Social Worker</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Social Service</b>	9c. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>55</b> Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Social Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Social Service</b>	11. BIRTHPLACE (City and state or country) <b>Mechanicsburg, Illinois.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>John E. Roth-Ross</b>	
13b. MOTHER'S MAIDEN NAME <b>Ruth Penn</b>		14. NAME OF HUSBAND OR WIFE <b>Mark B. Aylesworth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Robert P. Roth, Mechanicsburg, Illinois.</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>GANGRENE OF SMALL INTESTINE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1-2 DAYS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>MECHANICAL OBSTRUCTION, SMALL INTESTINE</b>			<b>1-2 DAYS</b>
DUE TO (c) <b>THROMBOCYTOPENIA</b>			<b>4 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>570.2</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <b>ITEM 13a, 17, 23c, 23d CORRECTED</b>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		BY AFFIDAVIT OF <b>Funeral Director</b> <b>8-10-59</b>	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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, 1958</b> to <b>MAY 27, 1959</b> and last saw her alive on <b>MAY 27, 1959</b> Death occurred at <b>12:05 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>C. Semilla, M.D.</b>		22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>5/27/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>5-27-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mechanicsburg City - Leel Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Mechanicsburg, Illinois.</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, 4700 Washington Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 28 '59</b>	26. REGISTRAR'S SIGNATURE <b>Roald Smith, M.D.</b>

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

*Stanley S. DeFournier*

Licensed Embalmer No. 4193

P. O. Address *St. Louis, 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.