

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**43113**

**PLACE OF DEATH**

County Scotland Co

Registration District No. 812

Township Johnston

Primary Registration District No. 6061

City Beautail (No. ....)

File No. ....

Registered No. 1

St. .... Ward)

**2. FULL NAME** Helen Ellene Aylward

(a) Residence No. .... St. .... Ward. ....

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

female

**4. COLOR OR RACE**

white

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

✓

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

**7. AGE**

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

6 months, 27

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

Scotland Co Mo

**10. NAME OF FATHER**

Roy Aylward

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Memphis Mo

**12. MAIDEN NAME OF MOTHER**

Fern Ruggie

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Beautail Ia

**14.**

INFORMANT (Address)

Mrs Roy Aylward

**15.**

FILED 1/16 1930

OTM Baker MD  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2

29

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 12/10 1929

**17.**

I HEREBY CERTIFY, That I attended deceased from Birth to Dec 11<sup>th</sup>, 1929, that I last saw her alive on Dec 10<sup>th</sup>, 1929, and that death occurred, on the date stated above, at about 5 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Spina-Bifid  
1594  
15713

(duration) yrs. mos. da.

**CONTRIBUTORY (SECONDARY)**

Hydrocephalus

(duration) yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

**19. DID AN OPERATION PRECEDE DEATH? DATE OF**

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H. G. Miller MD

12/11, 1930 (Address) Beautail Ia

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

**DATE OF BURIAL**

Prairie View

Dec 12 1929

**20. UNDERTAKER**

**ADDRESS**

E. G. Wellborn

Beautail Ia

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PHYSICIAN

OCCUPATION IS

AG

place station

of care

terms

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Scotland Registration District No. 812 File No. ....  
Township Johnston Primary Registration District No. 6061 Registered No. ....  
City ..... (No. .... St. .... Ward)

**2. FULL NAME**

Helen Helene Aylward  
(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>W</u> (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>3-13-1929</u>		
7. AGE	YEARS	MONTHS
	<u>6</u>	<u>27</u>
		DAYS
		<u>27</u>
		If LESS than 1 day, .... hrs. or .... min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer)..... (c) Name of employer.....		
9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)		
PARENTS	10. NAME OF FATHER	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)	
	12. MAIDEN NAME OF MOTHER	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)	

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/10 1929  
17. I HEREBY CERTIFY that I attended deceased from .....  
19..... to ..... 19.....  
that I last saw h..... alive on ..... 19....., and that  
death occurred, on the date stated above, at..... m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

..... (duration) ..... yrs. .... mos. .... ds.  
CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....  
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed)....., M. D.  
. 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT..... (Address)	19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
15. FILED <u>1/6</u> 19 <u>30</u> <u>J.H. Baker M.D.</u> REGISTRAR	20. UNDERTAKER	19 ADDRESS

**SUPPLEMENTARY**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW  
REGISTRARS should state CAREFULLY supplied. so that it may be properly classified.

10/10/10

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