

RECEIVED JUL 18 1939

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

21384
Do not use this space.

1. PLACE OF DEATH

(a) County Adair Registration District No. 4
(b) Township Tuskeville Primary Registration District No. 3001 Registered No. 149
(c) City Tuskeville, Mo. (d) Street No. Cross-Smith Hospital St. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Carl Ayer

(a) Residence, No. 650 W. Downing St. Downing, Mo.
(Usual place of abode, if no street address, write county or city) (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 Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 21, 1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
41 6 24

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Schuyler Co. MO.
(STATE OR COUNTRY)

13. NAME L.L. Beach

14. BIRTHPLACE (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

15. MAIDEN NAME Margaret Schupbach

16. BIRTHPLACE (CITY OR TOWN) Schuyler Co. Mo.
(STATE OR COUNTRY)

17. INFORMANT Carl Ayer
(ADDRESS) Lancaster Mo

18. BURIAL, CREMATION OR REMOVAL PLACE Downing Cemetery DATE 6 / 17 19. 39

19. FUNERAL DIRECTOR (NAME) Morehead's
(ADDRESS) Lancaster Mo

20. FILED June 16 19. 39 Spencer L. Freeman
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-15, 1939

22. I HEREBY CERTIFY, That I attended deceased from 6-12, 1939, to 6-15, 1939

I last saw her alive on 6-15, 1939. Death is said to have occurred on the date stated above, at 5:40 pm.

The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage

Date of onset 6-15-39

Other contributory causes of importance:

Hypertension

1939?

Name of operation Cranium section Date of 6-12-39
What test confirmed diagnosis? stab Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____

(Signed) J.P. Kump M.D., M. D.
(Address) Tuskeville, Mo.

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

I X-16005

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.

RECEIVED

District Health Officer No. 10

District File Number 7-39-1291

Date Filed JUL 13 1939

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.....

True & Minnie Morehead

Registered Apprentice No.

working under my personal supervision.

Signed

Morehead

Licensed Embalmer No. 3731-3680

P. O. Address Lancaster, Pa.

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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Do not use this space.

1. PLACE OF DEATH

(a) County Adair Registration District No. 4
 (b) Township _____ Primary Registration District No. 3001 Registered No. 149
 (c) City Kirksville (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs Helen Missouri

(a) Residence, No. _____ St. ayers
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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.
41 6 24

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Aug 14 19 39 Spencer L. Ince
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-15-1939

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. alive on _____, 19____. Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) J. J. Wain, M. D.

(Address) Kirksville Mo

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

