

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.

NOV 24 1939

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

36641  
Do not use this space.

**1. PLACE OF DEATH**

(a) County Marion Registration District No. 547  
 (b) Township Mason Primary Registration District No. 3029 Registered No. 285  
 (c) City Hannibal (d) Street No. \_\_\_\_\_ Levering Hospital 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** Amelia Julia Ayres

(a) Residence, No. 815 Bird St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dr. Albert J. Ayres

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 25, 1960

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	79	5	1	

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) Paloma  
 (STATE OR COUNTRY) Illinois

FATHER  
 13. NAME Louis B. Carl

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

MOTHER  
 15. MAIDEN NAME Catherine Boos

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

17. INFORMANT Mrs. H. L. Banks  
 (ADDRESS) South Fifth

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Mt. Olivet DATE 9/30/39

19. FUNERAL DIRECTOR (NAME) Smiths' Funeral Home  
 (ADDRESS) 902 Broadway Hannibal Mo

20. FILED Oct 2 1939 H. C. Fisher  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 26, 39

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw him alive on Sept 26, 1939. Death is said to have occurred on the date stated above, at 6:30 p.m.

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

Fractured skull with intracranial hemorrhage

Other contributory causes of importance: 186 W

Name of operation none Date of \_\_\_\_\_  
 What test confirmed diagnosis Chemist 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.  
Was found lying in street  
 Manner of injury thought to have fallen  
 Nature of injury from curb

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

If so, specify \_\_\_\_\_ (Signed) H. L. Murphy M. D.

(Address) Hannibal, Mo

**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.....

..... J.J.Marsh L.E.3932....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Crawford Smith*

Licensed Embalmer No...3814.....

P. O. Address Hannibal 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 this body is not embalmed, above space should be left blank.**