

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39566

Registration District No. 305

Primary Registration District No. 8422

Registrar's No. 32

1. PLACE OF DEATH:

(a) County GASCONADE
(b) City or town RURAL CANAAN TOWNSHIP
(c) Name of hospital or institution:
2 MILES EAST OF OWENSVILLE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community ABOUT 50 YRS. years, months or days

3. (a) PRINT
FULL NAME

SYLVESTER AYTES

3. (b) If veteran,
name war NO

3. (c) Social Security
No. ✓

4. Sex M

5. Color or
race W

6. (a) Single, widowed, married,
divorced MARRIED

6. (b) Name of husband or wife
EVELINA AYTES

6. (c) Age of husband or wife if
alive 71 years

7. Birth date of deceased SEPT-11-1865
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

74

2

-

hr.

min.

9. Birthplace

(City, town, or county)

TENNESSEE
(State or foreign country)

10. Usual occupation

FARMER

11. Industry or business

12. Name HIRAM AYTES

13. Birthplace TENNESSEE
(City, town, or county)

14. Maiden name MARY SEYMORE

15. Birthplace TENNESSEE
(City, town, or county)

16. (a) Informant's own signature Chester aytes

(b) Address Owensville Mo

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-14-1939
(Month) (Day) (Year)

(c) Place: burial or cremation OWENSVILLE CITY CEM.

18. (a) Signature of funeral director W. F. Gottenbacher

(b) Address Owensville Mo

19. (a) 11/13/39
(Date received local registrar)

(b) W. F. Gottenbacher
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County GASCONADE

(c) City or town RURAL
(If outside city or town limits, write "RURAL")

(d) Street No. 2 MILES EAST OF OWENSVILLE
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 11
year 1939 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from
5-28, 1939, to 11-11, 1939;

that I last saw him alive on 11-14, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Brain Injury
Fractured Skull - with

massive hemorrhage from nose & mouth.

Due to Fall from hay loft on head
while looking hay - death apparently

Due to instantaneous
severe brain injury.

Other conditions Chronic Cholelithiasis - mild
(Include pregnancy within 3 months of death)

Senility and senile sclerosis

Major findings: none

Of operations none

Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 11/11/39 at 3:30 p.m.

(c) Where did injury occur? Owensville R.D. Gasconade Co. Missouri
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home - at arm - at barn.
(Specify type of place)

While at work? yes - looking Means of injury Fall from
hay into hay loft hay loft on head.

23. Signature W. F. Gottenbacher (M. D. or other) M.D.
Address Owensville, Mo Date signed 11/13/39

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 me
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Mildred H H Winter

Licensed Embalmer No. 3838

P. O. Address Quenerville 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.