

Registration District No. **449** Primary Registration District No. **4267** Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH**  
(a) County **GREENE**  
(b) City or town **SPRINGFIELD**  
(c) Name of hospital or institution: **WALLACE MEMORIAL HOSP.**  
(d) Length of stay: In hospital or institution **18** days

3. (a) PRINT FULL NAME **HARRY DEAN AYRES JR.**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. **yes**

4. Sex **Male** 5. Color or race **white**  
6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Ruby Ayres** 6. (c) Age of husband or wife if alive **30** years

7. Birth date of deceased (Month) **Aug** (Day) **19** (Year) **1907**

8. AGE: Years **32** Months **11** Days **26** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Springfield Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **Cafe manager**

11. Industry or business **Cafe**

12. Name **Harry Dean Ayres Sr.** 13. Birthplace **Mo.**

14. Maiden name **Estyl Curtis** 15. Birthplace **Mo.**

16. (a) Informant **Mrs. Ruby Ayres**

(b) Address **Lake Ozark Mo.**

17. (a) **Rural** (b) Date thereof **July 29, 1940** (c) Place: burial or cremation **Green Hills Cem.**

18. (a) Signature of funeral director **W. W. Slinger** (b) Address **Springfield Mo.**

19. (a) **8-10-40** (b) **J. M. Conkle**

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Mo.** (b) County **Miller**  
(c) City or town **Lake Ozark**  
(d) Street No. \_\_\_\_\_ (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month **July** day **27** year **1940** hour **6:00** minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **July 26** 19 **40** to **July 27** 19 **40** that I last saw him alive on **7-27** and that death occurred on the date and hour stated above.

Immediate cause of death **Surgical shock amp 109**

Due to **Comminuted fracture of leg 18 hrs. Comp. comm. Fr left femur**

Due to **Cerebral contusion**

Other conditions **Multiple facetitis**  
**Fractures of body**

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (specify) **accident**

(b) Date of occurrence **7-26-40** (c) Where did injury occur? **Lebanon Estate Mo.**

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Public highway 4560**

While at work? **no** (Specify type of place) (e) Means of injury **Automobile**

23. Signature **Paula Jenkins** Address **Lebanon Mo.** Date signed **8/2/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

210  
P 231942

RECEIVED  
District Health Officer No. 7,  
District File Number 9-40-1324  
Date Filed 9-16-40

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed J. B. Klinger  
Licensed Embalmer No. 3358  
P. O. Address Springfield, In

**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.

No. 2B  
2-24-40  
122639

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State, File No. **28900**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **449**

Primary Registration District No. **4267**

Registrar's No. \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**  
 (a) County Laclede  
 (b) City or town Lebanon  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community \_\_\_\_\_  
years, months or days)

**3. (a) PRINT FULL NAME** Harry Dean Ayres, Jr.  
**3. (b) If veteran, name war** \_\_\_\_\_  
**3. (c) Social Security No.** \_\_\_\_\_

**4. Sex** m **5. Color or race** w **6. (a) Single, widowed, married, divorced** m  
**6. (b) Name of husband or wife** \_\_\_\_\_ **6. (c) Age of husband, or wife, if alive** \_\_\_\_\_ years

**7. Birth date of deceased.** (Month) (Day) (Year)

**8. AGE:** Years 32 Months 11 Days 26  
If less than one day, hr. min.

**9. Birthplace.** (City, town, or county) (State or foreign country)

**10. Usual occupation.**

**11. Industry or business.**

**12. Name.**

**13. Birthplace.** (City, town, or county) (State or foreign country)

**14. Maiden name.**

**15. Birthplace.** (City, town, or county) (State or foreign country)

**16. (a) Informant.**

**(b) Address.**

**17. (a) (b) Date thereof.** (Month) (Day) (Year)

**(c) Place: burial or cremation.**

**18. (a) Signature of funeral director.**

**(b) Address.**

**19. (a) (b) (Date received local registrar) (Registrar's signature)**

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**20. DATE OF DEATH:** Month July day 27  
 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
**21. I hereby certify that I attended the deceased from** \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
 and that death occurred on the date and hour stated above.

**MEDICAL CERTIFICATION**  
**22. Immediate cause of death:** Surgical shock  
Fract of rt femur  
Comp. Fract left femur  
**Other conditions (Include pregnancy within 3 months of death):**  
Cerebral concussion  
multiple lacerations  
abrasions of body  
**Major findings:**  
Sto car left road  
at a high speed on  
curved road  
**Of extent:** \_\_\_\_\_

**22. If death was due to external causes, fill in the following:**  
 (a) Accident, suicide, or homicide (specify) accident  
 (b) Date of occurrence 7-26-40  
 (c) Where did injury occur? Lebanon (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public Road U.S. 66.  
 While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_  
**23. Signature** Paul D. Jones, M.D. (M. D. or other)  
 Address Lebanon Mo. Date signed \_\_\_\_\_

SUPPLEMENTAL  
210 25

