

FILED JAN 8 - 1946

Registration District No. **300**

Primary Registration District No. **6202**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **TEXAS**
 (b) City or town **Rural (Crossed out) Rural**
 (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 **74 YRS**
 (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Texas '07**
 (c) City or town **Rural**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **4 mi. South Sumnersville**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **HATTIE BLANCH AYERS**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or race **WHITE**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Edgar N. Ayers**
 6. (c) Age of husband or wife if alive **77** years
 7. Birth date of deceased **July 22 1872**
 (Month) (Day) (Year)

8. AGE: Years **73** Months **4** Days **6**
 If less than one day hr. _____ min. _____

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER, FATHER

12. Name **Milton Brock**

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

14. Maiden name **Elizabeth Cain**

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

16. (a) Informant **Edgar N. Ayers**

(b) Address **Summersville Mo**

17. (a) **Burial** (b) Date thereof **11/30/45**
 (Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Gaylord V. Elliott**

(b) Address **Haustal Mo**

19. (a) **Dec 24 - 45** (b) **Mrs C.E. Murfin**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **28**
 year **1945** hour **10** minute **40 P.M.**

21. I hereby certify that I attended the deceased from **Nov 2 1945** to **Nov 27 1945**
 that I last saw her alive on **NOV 27 1945**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
apoplexy. Duration _____

Due to _____
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature **Dr. Lawrence Hough** (M. D. or other) **D.O.**
 Address **Summersville** Date signed **12/30**

1609

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

working under my personal supervision.

No Embalming
Registered Apprentice No.

Signed

Licensed Embalmer No.

P. O. Address

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, fact should be so stated above.

Registration District No. 355

Primary Registration District No. 6202

Registrar's No. _____

1. PLACE OF DEATH: Texas
(a) County _____
(b) City or town Rural Carroll
(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

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Wattie B. Ayers
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex F 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 July 22, 1870
(Month) (Day) (Year)

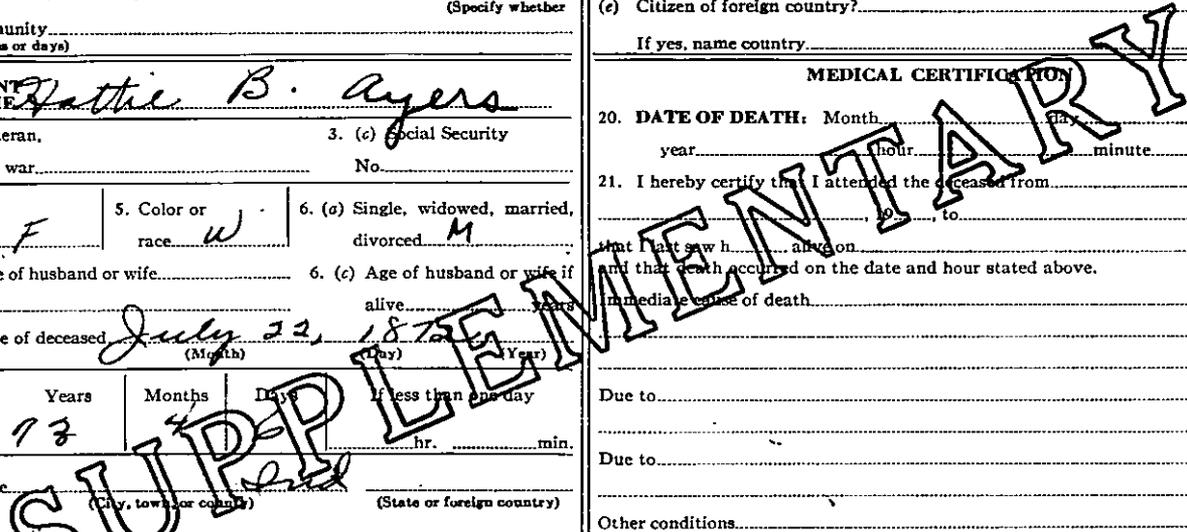
MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____ Year _____ Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months _____ Days _____ If less than one day _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

Duration _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

10. Usual occupation _____
11. Industry or business _____
MOTHER, FATHER {
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) _____ (Registrar's signature)
(Data received local registrar)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) _____ (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Date signed _____



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

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