

FEDERAL BUREAU OF INVESTIGATION

National Office of Vital Statistics

FILED MAR 6 1948

Registration District No. 29488

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5955

State File No. 5769

Registrar's No. 1

1. PLACE OF DEATH:

- (a) County Pike  
(b) City or town Ashburn  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Home Health Care, Inc.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 (Specify whether

In this community 1 years, months or days)

3. (a) PRINT FULL NAME Mary Olive Ayers

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 5. Color or race White

6. (b) Name of husband or wife John

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

6. (c) Age of husband or wife if alive 10 years

7. Birth date of deceased December 6, 1880  
(Month) (Day) (Year)

8. AGE: Years 67 Months 2 Days 10 If less than one day hr. min.

9. Birthplace Marion Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business

12. Name Phillip Carter

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

14. Maiden name Elizabeth Roberts

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

16. (a) Informant Rosal Ayers

(b) Address Ashburn, Mo.

17. (a) Burial (b) Date thereof 2-19-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashburn, Mo.

18. (a) Signature of funeral director James O'Donnell

(b) Address Frankford, Mo.

19. (a) 2-18-48 (b) Bernice Caelen  
(Date received local registrar) (Registrar's signature)

Jefferson City Printing Co. (Licensed Emballer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Marion  
(c) City or town Ashburn  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural Ashburn, Mo.  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February, day 16, year 1948, hour 6:22, minute P.M.

21. I hereby certify that I attended the deceased from 1947 to Feb. 16, 1948, that I last saw her alive on Feb. 13, and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Failure

Due to age  
stroke of apoplexy

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature E. P. Hansen Address Frankford, Mo. Date signed 2/18/48

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 10  
District File Number 3-48-435  
MAR 4 1948  
Date Filed

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

*Michael J. O'Rourke*

Licensed Embalmer No. 3246

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, fact should be so stated above.