

FILED FEB 21 1949

 THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. 4444

BIRTH NO. _____		REG. DIST. NO. <u>106</u>		PRIMARY REG. DIST. NO. <u>4178</u>		Registrar's No. <u>3</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Dunklin</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Dunklin</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>35</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Holcomb</u>		c. LENGTH OF STAY (in this place) <u>12 mos.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Parma</u>		0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Cochrane Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Local</u>			
3. NAME OF DECEASED			4. DATE OF DEATH			5. SEX	
a. (First) <u>John</u>	b. (Middle) <u>Morgan</u>	c. (Last) <u>Aylor</u>	(Month) <u>Feb</u>	(Day) <u>5</u>	(Year) <u>1949</u>	Male <u>0</u>	6. COLOR OR RACE <u>White</u>
(Type or Print)							
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>July 25 1880</u>		9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR	IF UNDER 1 HR.
				Months <u>6</u>	Days <u>10</u>	Hours <u>0</u>	Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Weakley County Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>1</u>	
13a. FATHER'S NAME <u>Thomas Aylor</u>		13b. MOTHER'S MAIDEN NAME <u>Mildred Tallafora</u>		14. NAME OF HUSBAND OR WIFE <u>X</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Lucille Truett</u>		ADDRESS <u>Parma Mo.</u>	
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lobar Pneumonia</u>					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES <u>Tuberculosis</u>					
		Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) <u>E 9030</u>					
		DUE TO (c) <u>Fell on ice &amp; fracture</u>					
		II. OTHER SIGNIFICANT CONDITIONS <u>Fell on ice &amp; fracture</u>					
		Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						ADDITIONAL	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Farm</u>		21c. (CITY, TOWN, OR TOWNSHIP) <u>Parma, Mo.</u>		21d. (COUNTY) AND DISTRICT (STATE) <u>New Madrid, Mo.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>slipped on ice &amp; fell</u>			
22. I hereby certify that I attended the deceased from <u>Feb 4, 1949</u> , to <u>2/5, 1949</u> , that I last saw the deceased alive on <u>2/4, 1949</u> , and that death occurred at <u>6:30 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Wm. E. Cochran</u> (Degree or title) <u>D.</u>				23b. ADDRESS <u>Holcomb</u>		23c. DATE SIGNED <u>7/2/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Feb. 5 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Maple Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Cantharville Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 15, 1949</u>		REGISTRAR'S SIGNATURE <u>J. A. Anderson</u>		5. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Pike</u>		ADDRESS <u>Cantharville, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

0.48

RECEIVED

District Health Office No. 2

District File Number 249-22

Date Filed 2-18-4

FEB 23 1949

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*William D. Pike*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. 4484

P. O. Address Carthersville, 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.