

# THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **20218**Registrar's No. **71**

BIRTH NO. _____		REG. DIST. NO. <b>200</b>		PRIMARY REG. DIST. NO. <b>5724</b>		Registrar's No. <b>71</b>	
1. PLACE OF DEATH a. COUNTY <b>Macon</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Macon</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural Eagle Twp</b>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural Eagle Twp</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>none</b>				d. STREET ADDRESS (If rural, give location) <b>North of Macon</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>Frank</b>		b. (Middle)		c. (Last) <b>Ayers</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Feb 3 1877</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>		9. AGE (In years last birthday) <b>72</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Jenn Ayers</b>		13b. MOTHER'S MAIDEN NAME <b>Louisa Stone</b>		14. NAME OF HUSBAND OR WIFE <b>Edith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Edith Ayers</b>		ADDRESS <b>Macon, MO</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Prostate</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <input checked="" type="checkbox"/> DUE TO (c) <b>Obtention of leg March 25 49</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>1948</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
19a. DATE OF OPERATION <b>March 20</b>		19b. MAJOR FINDINGS OF OPERATION <b>Ca of Prostate Transurethral Resection</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>5:10</b> , 19 <b>48</b> , to <b>Apr 8</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>Apr 6</b> , 19 <b>49</b> , and that death occurred at <b>10</b> m., from the causes and on the date stated above.							
23a. SIGNATURE <b>M. P. Conroy M.D.</b> (Degree or title)				23b. ADDRESS <b>Macon MO</b>		23c. DATE SIGNED <b>6-23-49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>4-10-49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>MT Labor</b>		24d. LOCATION (City, town, or county) (State) <b>Atlanta MO</b>	
DATE REC'D BY LOCAL REG. <b>7-2-49</b>		REGISTRAR'S SIGNATURE <b>Ruth Mcneely</b>		185 25. FUNERAL DIRECTOR'S SIGNATURE <b>Stephens &amp; Goodding</b>		ADDRESS <b>Macon</b>	

(Licensed Embalmers' Statement on Reverse Side)

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

RECEIVED

District Health Officer No. \_\_\_\_\_

District File Number 7-49-11

Date Filed JUL 1 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 \_\_\_\_\_

working under my personal supervision.

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

Student .....  
Student Embalmer

Signed C. L. Stephens

Licensed Embalmer No. 3657

P. O. Address Wacon, 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.