

FILED FEB 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2292**
Registrar's No. **0479**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 0479	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #10				STREET ADDRESS (If rural, give location) 22 North Spring Avenue.			
3. NAME OF DECEASED (Type or Print) a. (First) WM.		b. (Middle) RUFUS.		c. (Last) AYERS		4. DATE OF DEATH (Month) (Day) (Year) 1 16 55	
5. SEX Male 0		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Feb 26, 1906	
9. AGE (In years last birthday) 48		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Interior & Ext		11. BIRTHPLACE (City and State or Foreign Country) Gadsden, Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME George Ayers			13b. MOTHER'S MAIDEN NAME Della Bryant			14. NAME OF HUSBAND OR WIFE Eunice Ayers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Nil		17. INFORMANT'S SIGNATURE OR NAME Eunice Ayers		ADDRESS 4059 Westminister Pl.	
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) Brain Tumor (Glioblastoma multiforme) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION 11-15-54		19b. MAJOR FINDINGS OF OPERATION Brain tumor non resectable				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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 193X			
22. I hereby certify that I attended the deceased from 11-10, 1954 , to 1-16, 1955 , that I last saw the deceased afte on 1-16 , 1955, and that death occurred at 9:30 Am. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Ignace Costello, M.D.				23b. ADDRESS Medical Director 1515 Lafayette Ave.		23c. DATE SIGNED 1-17-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1-19-55		24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) Normandy, Missouri.	
DATE REC'D BY LOCAL REG. JAN 17 1955		REGISTRAR'S SIGNATURE Charles Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington Blvd	

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

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..

Student.....
Signature of Student Embalmer

Signed *J. W. B. Embler*

Licensed Embalmer No. *3653*

P. O. Address *J. W. B. Embler*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.