

FILED MAR 31 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-012638  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 811

300  
1-57  
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1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kirkwood</u> <u>4673</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Marys Hospital</u>		Length of stay in 1b <u>1 day</u>	d. STREET ADDRESS (If outside, give location) <u>947 Clay Ave.</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET ELIZABETH AYRES</u>			4. DATE OF DEATH Month Day Year <u>March 19, 1958</u>			
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1908</u>	9. AGE (In years last birthday) <u>49</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Willard Cunningham</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Dickson</u>	14. NAME OF HUSBAND OR WIFE <u>Dr. Ryland M. Ayres</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Dr. Ryland M. Ayres</u>	Address <u>Kirkwood, Mo.</u> <u>947 Clay Ave.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chr. Cardiovascular Disease &amp; Hypertension</u>		<u>2 years plus</u>
	DUE TO (c) <u>H43X</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from June 1956 to March 19, 1958 and last saw her alive on March 19, 1958  
Death occurred at 12:30 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Harvey Oct. and</u>	22b. ADDRESS <u>2816 Sutter - St. Louis, 17, Mo.</u>	22c. DATE SIGNED <u>3/20/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>3/21/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Crematory</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County Missouri.</u>
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24. FUNERAL DIRECTOR <u>C.R. Lupton and sons</u>	ADDRESS <u>7233 Delmar</u>	25. DATE RECD. BY LOCAL REG. <u>3-21-58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert P. Donke M.D.</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Wells Branch  
County -

**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 Arnold W. Schreine

Licensed Embalmer No. 3864  
P. O. Address St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.