RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–029770
STATE FILE NUMBER

FILED VS SEP 3 1959

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 254

1. PLACE OF DEATH
a. COUNTY: Marion
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Hannibal — Length of stay in 1b: 14 Mts.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Clark Rest Home — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Marion
c. CITY OR TOWN: Hannibal — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 110 Collins — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: MARY Middle: SUSAN Last: AYERS
4. DATE OF DEATH: Month August Day 16 Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 11/15/1874
9. AGE (last birthday): 84 — IF UNDER 1 YEAR: Months 9 Days 1 — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Hannibal Missouri
12. CITIZEN OF WHAT COUNTRY: U S A
13a. FATHER'S NAME: William A. Wiseman
13b. MOTHER'S MAIDEN NAME: Mildred
14. NAME OF HUSBAND OR WIFE: Harry C. Ayers (Deceased)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. W. E. Hicks Hannibal Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis, Paget's disease — INTERVAL BETWEEN ONSET AND DEATH: 1 day.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 8-13-59, to 8-13-59 and last saw her/him alive on 8-13-59
Death occurred at 10:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: W. F. Roller, (Degree or title) M.D.
22b. ADDRESS: Hannibal, Mo.
22c. DATE SIGNED: Aug 22/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 8/19/1959
23c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery
23d. LOCATION (City, town, or county) (State): Hannibal Missouri
24. FUNERAL DIRECTOR: W. Crawford Smith — ADDRESS: Hannibal Misssouri
25. DATE RECD. BY LOCAL REG.: 8-25-59
26. REGISTRAR'S SIGNATURE: Dr. E. M. Lucke By W. Fisher

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF — DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed_____

Licensed Embalmer No. 3814

P. O. Address Hannibal Miss

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.