

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025012

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 197 Primary Registration District No. 3040 Registrar's No. 154

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 24 1963

1. PLACE OF DEATH a. COUNTY <u>Livingston</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u> Length of stay in 1b <u>1 Month</u> c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Susan's Nursing Home</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u> c. CITY OR TOWN <u>Hale</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Route 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
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3. NAME OF DECEASED First <u>Melissa</u> Middle <u>C.</u> Last <u>Ayers</u>			4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1963</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/23/1886</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and state or country) <u>Fortescue, Missouri U.S.A.</u>	
13a. FATHER'S NAME <u>John Henry Conner</u>		13b. MOTHER'S MAIDEN NAME <u>Jane Curnutt</u>		14. NAME OF HUSBAND OR WIFE <u>Robert Burton Ayers</u>	
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> </u>		
17. INFORMANT <u>Myrl Atkisson, Cameron, Missouri</u>			Address <u> </u>		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma with generalized metastasis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>origin of carcinoma is original site not Kaposi's</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic suppurative</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.)	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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	

21: I attended the deceased from 6-4-63 to 6-18-63 and last saw her ^{her} alive on 6-11-63.
 Death occurred at 1:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) Joseph F. Gale M.D. 22b. ADDRESS Chillicothe, Mo 22c. DATE SIGNED 6-19-63 (State)

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 20 Jun 63 23c. NAME OF CEMETERY OR CREMATORY Wheeling Cemetery 23d. LOCATION (City, town, or county) Wheeling, Missouri (State)

24. FUNERAL DIRECTOR Norman Funeral Home, Chillicothe, Mo ADDRESS 25. DATE RECD. BY LOCAL REG. June 20, 1963 26. REGISTRAR'S SIGNATURE Amalee Taylor

(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59
 10595
 20590
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 4 1
 5 2
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 7 0
 8 2
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 12 86-0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

JUL 8 1963

2820
1020

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2-22

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 John A. Rodgers

Licensed Embalmer No. 4963

P. O. Address Chillicothe, Missouri

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.

Dowell