

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014643

STATE FILE NUMBER

2 3174

16 APR 20 1959

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3 Enroute City Hospital			d. CITY OR TOWN St. Louis (If outside, give location) 1806a So. 10th St.		
e. LENGTH OF STAY IN lb			f. STREET ADDRESS Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) DeWitt T. Ayers			4. DATE OF DEATH Month Day Year March 27, 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 10, 1896	9. AGE (In years, last birthday) 82	10. UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Utility Man			10b. KIND OF BUSINESS OR INDUSTRY Cargo Carriers, Inc.	11. BIRTHPLACE (City and state or country) Hickman, Ky.	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Arch Price Ayers			13b. MOTHER'S MAIDEN NAME Ada Belle Johnson	14. NAME OF HUSBAND OR WIFE Helen Ayers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 11499-28-1951	17. INFORMANT Mabel Ayers Allen, Rt.1 - Hickman, Ky.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			INTERVAL BETWEEN ONSET AND DEATH Coronary Occlusion		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c)			Coronary Sclerosis Cirrhosis of the Liver		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5-81.0			19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 INJURY a.m. p.m.	Hour	Month, Day, Year			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION Hickman, Ky.	COUNTY STATE Hickman, Ky.
21. I attended the deceased from _____ and last saw him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE DeWitt T. Ayers		(Degree or title) 3	22b. ADDRESS 1300 Elkhorn	22c. DATE SIGNED 3/30/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-2-59	23c. NAME OF CEMETERY OR CREMATORIAL City Cemetery	23d. LOCATION (City, town, or county) Hickman, Ky.	(State)	
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.	ADDRESS	25. DATE RECD. BY LOCAL REG. MAR 30 '59		26. REGISTRAR'S SIGNATURE John Smith, M.D. m o b	

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

Licensed Embalmer No. 3575

P. O. Address M. L. Smith, MD

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.