

No. 2  
-5-43  
-17-39  
X36671

FILED SEP 13 1944

Primary Registration District No. **5375**

Registrar's No. **225**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Dekalb**

(b) City or town **Rural Dallas Twp** (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Rural Dallas Twp**

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community **Entire Life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Dekalb** **32**

(c) City or town **Rural Dallas Twp** (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Maggie M. Ackley**

3. (b) If veteran, name war **X**

3. (c) Social Security No. **X**

4. Sex **F**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Nov 18 1875** (Month) (Day) (Year)

8. AGE: Years **68** Months **8** Days **22** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation **House Keeper**

11. Industry or business \_\_\_\_\_

MOTHER, FATHER

12. Name **Samuel Ackley**

13. Birthplace **NY** (City, town, or county) (State or foreign country)

14. Maiden name **Mariemna Brown** (City, town, or county) (State or foreign country)

15. Birthplace **Ind** (City, town, or county) (State or foreign country)

16. (a) Informant **Girtrude Ackley**

(b) Address **Maysville, Mo**

17. (a) **Burial** (b) Date thereof **8/12/44** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Fagrport, Mo**

18. (a) Signature of funeral director **J. Schomer**

(b) Address **Pattonburg, Mo**

19. (a) **8-25-1944** (b) **John Clorne** (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **10** year **44** hour **II** minute **A.** M.

21. I hereby certify that I attended the deceased from **May 13 1944** to **Aug 10 1944** that I last saw **live** on **Aug 10 1944** and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion**

Due to **arteriosclerosis**

Other conditions **Cerebral Hemorrhage** (Include pregnancy within 3 months of death)

Duration **10 yrs?**

Major findings: Of operations **94a**

Of autopsy \_\_\_\_\_

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

23. Signature **Dr. Harold Fowler** (Specify type of place) (e) Means of injury **2**

Address **Maysville, Mo** Date signed **8-12-44**

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**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed *H. G. Gomer*.....

Licensed Embalmer No. 2857.....

P. O. Address. Pattonsburg, 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 this body is not embalmed, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

*Sept*

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County DeKalb  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community Life \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME

Maggie M. Ackley

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov 18 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day, \_\_\_\_\_ min.

9. Birthplace DeKalb Co, Ga (City, town or country)

(State or foreign country) Missouri

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) \_\_\_\_\_

(State or foreign country) \_\_\_\_\_

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) \_\_\_\_\_

(State or foreign country) \_\_\_\_\_

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 23 year 1944 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**SEARCHED**  
**SERIALIZED**  
**INDEXED**  
**FILED**  
AUG 23 1944  
DEKALB COUNTY, GA

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