

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Audrain
Township Loddonia
or
Village
or
City

Registration District No. 24 File No. 13717
Primary Registration District No. 4018 Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Fielding Spencer Akridge

PERSONAL AND STATISTICAL PARTICULARS

SEX M. COLOR OR RACE W. SINGLE M.
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Feb. 14, 1840
(Month) (Day) (Year)

AGE 72 yrs. no mos. 28 ds. If LESS than
1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE
(City or town, State or foreign country) K. Y.

PARENTS
NAME OF FATHER Fielding Akridge
BIRTHPLACE OF FATHER K. Y.
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Elizabeth Akridge
BIRTHPLACE OF MOTHER Loddonia
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Clara Laque
(ADDRESS) Loddonia

Filed Apr. 1, 1917 T. M. Morrow
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr. 11, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Apr. 5, 1917, to Apr. 11, 1917, that I last saw him alive on Apr. 11, 1917, and that death occurred, on the date stated above, at 5 p.m., The CAUSE OF DEATH* was as follows:
Acute dilatation of heart

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory
(SECONDARY) (Duration) 18 yrs. ___ mos. ___ ds.

(Signed) T. M. Morrow M. D.
Apr. 12, 1917 (Address) Loddonia

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 4 yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence on farm Audrain co mo

PLACE OF BURIAL OR REMOVAL Loddonia mo DATE OF BURIAL Apr. 12, 1917

UNDERTAKER H. S. Brown ADDRESS Loddonia mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

County _____

Township _____ or _____
Village _____ or _____
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

(If death
hospital
give its
of street at

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If rite the word)
DATE OF BIRTH		

AGE _____ (Month) _____ (Day) _____ (Year) _____

IF LESS than
1 day, _____ hrs.
or _____ min.?

_____ yrs. _____ mos. _____ ds.

OCCUPATION _____
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE _____
(City or town, State or foreign country)

NAME OF FATHER _____

BIRTHPLACE OF FATHER _____
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER _____
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____

(ADDRESS) _____

Filed _____, 191____
REGISTRAR

DATE OF DEATH _____ (Month) _____ (Day) _____

I HEREBY CERTIFY, that I attended death _____, 191____, to _____, that I last saw h_____ alive on _____ and that death occurred, on the date stated above, at _____
The CAUSE OF DEATH* was as follows: _____

(Duration) _____ yrs. _____ mos.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos.

(Signed) _____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
(1) LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TROOP RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ mos. In the State _____ yrs. _____ mos. Where was disease contracted if not at place of death? _____ Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____

UNDERTAKER _____ ADDRESS _____

"Typhoid pneumonia"; Lobar pneumonia; Broncho-pneumonia ("Pneumonia," unqualified, is indefinite);