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

Do not use this space.

35102

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

File No. .....

Registered No. 10252

City St. Louis (No. City Hospital St. ..... Ward)

10938

2. FULL NAME Fred Ackerman

(a) Residence. No. 2609 S. Grand Ave. 17 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Anna Ackerman

6. DATE OF BIRTH (MONTH, DAY AND YEAR): March 27, 1849

7. AGE: Years 78 | Months 7 | Days 19 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Dry goods merchant
(b) General nature of industry, business, or establishment in which employed (or employer): (Retired)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): New York

PARENTS

10. NAME OF FATHER: Theodore Ackerman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Switzerland

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Hospital Information

14. INFORMANT: E. Roman
(Address): City Hospital

15. FILED NOV 16 1927 19 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov 15 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov 14, 1927, to Nov 15, 1927 that I last saw him alive on Nov 15, 1927 and that death occurred, on the date stated above, at 8 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute intestinal obstruction due to torsion of Splenic flexure of colon.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 11861
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? Yes. DATE OF Nov 14, 1927.
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Robert H. Simpson, M.D.
11/15, 1927 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Calvary Cem. DATE OF BURIAL: Nov 16 1927

20. UNDERTAKER: Philander Craig ADDRESS: 4468 Washington

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.

Ackerman