

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

Do not use this space.

1. PLACE OF DEATH

County Buchanan
Township _____
City St. Joseph, (No. _____)

Registration District No. 85
Primary Registration District No. 1001
Noyes Hospital

File No. 9721
Registered No. 433
St. _____ Ward _____

2. FULL NAME

Robert Lee Akin

(a) Residence. No. 3524 Olive St. St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 24 ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 6, 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
0 1 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

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

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Joseph, Mo.

10. NAME OF FATHER

William B. Akin

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

So. Dakota

12. MAIDEN NAME OF MOTHER

Ida Baldus

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis, Mo.

14.

INFORMANT

Wm. B. Akin

(Address)

3524 Olive St.

15.

FILED

1929

REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar, 30, 1929 19 _____

17.

I HEREBY CERTIFY, That I attended deceased from March 26, 1929, to March 30, 1929, that I last saw him alive on March 30, 1929, and that death occurred, on the date stated above, at 4:30 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia, acute.

(duration) _____ yrs. _____ mos. 14 ds.

CONTRIBUTORY (SECONDARY)

Obli. media, acute

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) W. Rager Moore M. D.

3/31, 1929 (Address) St. Joseph, Mo

*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

DATE OF BURIAL

Mt. Olivet Cemetery

Apr. 1, 1929

20. UNDERTAKER

ADDRESS

W. Meinhoffer 1302 Faraon St.

