

Y 29 1929

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

Do not use this space.

16915

1. PLACE OF DEATH

County Saline
Towship Liberty
City _____ (No. _____)

Registration District No. 801
Primary Registration District No. 6045

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Marshall Beaman Akeman

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

Length of residence in city or town where death occurred 57 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)

Married

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

Annice Akeman

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

March 13-1872

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>57</u>	<u>1</u>	<u>4</u>	<u>—</u>

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(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) Saline Co Mo

10. NAME OF FATHER

Peter Akeman

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Pennsylvania

12. MAIDEN NAME OF MOTHER

Emily J Harris

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ill.

14.

INFORMANT W. C. Akeman
(Address) Shackelford Mo

15.

FILED 4-19-1929 A. H. Ringum
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

April 17 1929

17.

I HEREBY CERTIFY, That I attended deceased from Jan 20, 1929, to April 17, 1929
that I last saw him alive on April 17, 1929, and that death occurred, on the date stated above, at 7:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Organic Heart Disease
42A (Respiration/Vitality) Mitral
95B

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Home
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Clyde W. Pearson M. D.
April 15, 1929 (Address) Swat Springs 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

Farmer

DATE OF BURIAL

April 19 1929

20. UNDERTAKER

Jeise Harvey

ADDRESS

Swat Springs Mo

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.

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