

**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

Registration District No. 85

Primary Registration District No. 1001

(No. Missouri Methodist Hospital)

File No. 8827

Registered No. 255

St. _____ Ward)

2. FULL NAME James Akers

(a) Residence. No. Salvation Army Barracks (City Hall) Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 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)

Unknown

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
(OR) WIFE OF

Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) About 1892

7. AGE

YEARS

MONTHS

DAYS

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

39

UNKNOWN

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work.

Not occupied

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

Formerly a teamster

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Unknown

(STATE OR COUNTRY)

Unknown

31

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

Unknown

14.

INFORMANT Salvation Army records

(Address) St. Joseph, Mo.

15.

FILED

19

John R. Bender

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 2- 19 31

17.

I HEREBY CERTIFY, That I attended deceased from

Feb 28, 1931, to Mar 2, 1931

that I last saw him alive on Mar 2, 1931, and that
death occurred, on the date stated above, at 9 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lung Abscess, Rt. Lower
lobe. Septicemia tubercular
23P

(duration) unknown yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)

Infection left thigh

(duration) unknown yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

Same

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

E. M. Shores M. D.

Mar. 7, 19 31 (Address) 317 1/2 Park Patrick Bldg
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

Mt. Olivet Cemetery

DATE OF BURIAL

Mar. 11 19 31

20. UNDERTAKER

H. O. Siderfader

ADDRESS

1802 Union st.

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.

11
5
9
21 1931

MAR 11 1931

