

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

40185
Do not use this space.

1. PLACE OF DEATH

(a) County McDonal Registration District No. 1149
 (b) Township 7 Primary Registration District No. 5697
 or
 (c) City Jane (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

DAVID A AKCHURST
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah England
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 28, 1847
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
92 2 3
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Minister
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 31 1939
 22. I HEREBY CERTIFY, That I attended deceased from 6-1- 1938, to 10-31- 1939
 I last saw him alive on 8-1- 1939. Death is said to have occurred on the date stated above, at 6a m.
 The principal cause of death and related causes of importance were as follows:

Diabetes

Date of onset

(9)

Other contributory causes of importance: 54
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) Cardwell, M. D.
 (Address) Stella Mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Pennsylvania

FATHER

13. NAME Not known

MOTHER

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

15. MAIDEN NAME Not known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

17. INFORMANT (ADDRESS) Lutitia Wagner
Jane mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Roller Cem DATE Nov. 1 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Pogue & Son
Wheaton, Mo.

20. FILED 11-30 1939 Lee O Carmel
 Local Registrar.

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.

RECEIVED

District Health Officer No. 6,

District File Number 2039-2534

Date Filed DEC 8 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Wm. Morris Tague

Registered Apprentice No.....

working under my personal supervision.

Signed

Wm. Morris Tague

Licensed Embalmer No. 3442

P.O. Address Wheaton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.