DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15280

Registration District No. MAY 16 1940 448

Primary Registration District No. 5608

Registrar's No. 7

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Rural Union (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 (Specify whether days, months or years)
In this community 2 1-3

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Laclede
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Ida Jane Ackeraid
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex 2
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Isaac Ackeraid
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov (Month) 3 (Day) 1858 (Year)

8. AGE: Years 81 Months 4 Days 26 If less than one day hr. min.

9. Birthplace Gentry Co Mo (City, town, or county) 6 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Dont Know
13. Birthplace " " (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Sarah E Duncan
15. Birthplace Dont Know (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Isaac Ackeraid
(b) Address 802 W 2nd Lebanon Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/30/40 (Month) (Day) (Year)
(c) Place: burial or cremation New Hope
18. (a) Signature of funeral director W. E. Hallman
(b) Address Lebanon Mo
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29
year 1940 hour 11 minute 45a M.

21. I hereby certify that I attended the deceased from 3-23, 1940 to 3-29, 1940 that I last saw h[illegible] alive on 3-29, 1940; and that death occurred on the date and hour stated above.

Duration
Immediate cause of death Hemorrage of brain
Due to H T Johnson
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature J W Lindsay (M. D. or other)
Address Conway Date signed 4-22-40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
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.

Rev. 5-17-39

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

No Embalming, Registered Apprentice No.

working under my personal supervision.

Signed W. E. Hahman

Licensed Embalmer No. 4107

P. O. Address Lebanon Mo

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.

S. No. 2B
4—2-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15·280

Registration District No. 448 — Primary Registration District No. 5668 — Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) ~~City or town~~ Union T. P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Ida Jane Dekroid
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 81 | Months 4 | Days 26 | If less than one day: hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
FATHER 13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
MOTHER 15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 6-6-1940 (Date received local registrar) (b) Ara Montgomery (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from 19..., to 19...;
that I last saw h... alive on 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature F. N. Lindsay (M. D. or other)
Address Conway Mo. Date signed

SUPPLEMENTARY