

U6-21-1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

25919

State File No. _____

Registration District No. 668

Primary Registration District No. 3032

Registrar's No. 229

1. PLACE OF DEATH:

(a) County: Pettis
(b) City or town: Sedalia
(c) Name of hospital or institution: Bothwell Memorial Hosp.
(d) Length of stay: In hospital or institution 6 weeks
In this community 1 year
years, months or days

3. (a) PRINT FULL NAME Mrs. Minnie Jasper Akins

3. (b) If veteran, name war _____ 3. (c) Social Security No. 496-16-0985

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Troy Akins 6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased Dec. 13, 1900
(Month) (Day) (Year)

8. AGE: Years 39 Months 7 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Cole, Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Jasper

13. Birthplace unknown
(City, town, or county) (State or foreign country)

14. Maiden name Minnie Lee

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Troy Akins

(b) Address 1002 East 5th, Sedalia, Mo.

17. (a) Burial (b) Date thereof July 22, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill

18. (a) Signature of funeral director Mrs. Harrie Sneed

(b) Address Sedalia, Mo.

19. (a) 7-22-40 (b) Mrs. Harrie Sneed
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pettis
(c) City or town Sedalia
(d) Street No. C.C. Camp
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 20
year 1940 hour 5 minute 0 M.

21. I hereby certify that I attended the deceased from 12/1/1939 to 7-20-1940
that I last saw _____ alive on 7-20 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Transition

Due to obstruction of bowel on May 40

Due to obstruction bowel Feb. 1940

Other conditions pelvic infection
(Include pregnancy within 3 months of death)

Major findings: gangrene of small intestine

Of operations _____

Of autopsy not done

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 _____

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? 90%

(Specify type of place) _____

(e) Means of injury _____

23. Signature Dr. Sger (M. D. or other) _____

Address Sedalia Mo Date signed 7/22/40

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

12212

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 8-9-40

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28-949

Registration District No. 668

Primary Registration District No. 3082

Registrar's No. 229

1. PLACE OF DEATH:

(a) County Polk
(b) City or town Seaside
(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.....

In this community _____ (Specify whether
years, months or days)

3. (a) PRINTER Mrs. Mennie Walker (Hines)

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 M

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 Months Days If less than one day

 39 7 7 hr min

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.

11. Industry or business

FATHER { 12. Name.....
13. Birthplace.....
(City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name (City, town, or county) (State or foreign country)
15. Birthplace (City, town, or county) (State or foreign country)

(a) Informant.....
(b) Address.....

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) _____ (Data received local registrar) (b) _____ (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 20
year 1940 hour _____ minute _____ M

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____.

and that death occurred on the date and hour stated above.

Immediate cause of death Infection Duration 2

Obstruction of Bowel

Due to *destruction of bowl*

1940

from hepatitis, Ophiostoma

Other conditions. Sexual infection
 Include pregnancy within 3 months of death.

Major findings:		PHYSICIAN
Of small intestine.		

Underline the cause to which death

Of autopsy..... should be charged statistically. W

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)

23. Signature [Signature] (M. D. or other) _____

Address _____ Date signed _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

25949

Registration District No. 668

Primary Registration District No. 3032

Registrar's No.

1. PLACE OF DEATH

- (a) County Pettis
(b) City or town Sedalia
(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

In this community _____

(Specify whether

years, months or days)

3. DECEASED'S NAME

3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 39 Months 7 Days 7 If less than one day _____ hr _____ min

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

- (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 20
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

- Immediate cause of death thrombosis Duration _____

- Obstruction of bowels
Dec 1940

- Obstruction of bowels
2 Feb 1940

- Other conditions pelvic infection

- (Include pregnancy within 3 months of death)

- Major findings gangrene of small intestine

- Of operations cause of obstruction

- was adhesion

- Of autopsy cause of pelvic infection

- was due to miscarriage

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, 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? _____

- While at work? _____ (Specify type of place)

- (a) Means of injury _____

23. Signature _____ (M. D. or other) _____

- Address _____ Date signed _____