

No. 2  
1-10-39  
17-39  
X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **29835**

Registration District No. **824**

Primary Registration District No. **6076**

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH**

(a) County Shannon

(b) City or town Shannon  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County Shannon

(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.

**8. (a) PRINT FULL NAME** James Leon Akers 262

8. (b) If veteran, name war X 8. (c) Social Security No. X

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug - 2 - 1940  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		<u>1</u>	<u>2</u>	— hr. — min.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Aug day 4  
year 1940 hour 3 minute P M.

21. I hereby certify that I attended the deceased from 9-4-40  
9-4- 1940, to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him alive on 9-4- 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Branchitis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

**MOTHER** { 12. Name Goldie Akers

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

14. Maiden name Velma Johnson

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

16. (a) Informant B Akers

(b) Address Branney MO

17. (a) Rural (b) Date thereof 9-5-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Black Hill Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address \_\_\_\_\_

19. (a) 9-5-40 (b) Frank Hyde MD  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

While at work? (Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

23. Signature Frank Hyde (M. D. or other) \_\_\_\_\_

Address Emmes MO Date signed 9-5-40

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

RECEIVED

Dist

Embalmer

District

Number

940954

Date Filed

---

---

**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.**