

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31039

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3602

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Kansas City General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Mo. & 18 days
(Specify whether in)
In this community 30 yrs
years, months or days

3. (a) PRINT FULL NAME CHARLES AKERLAND

3. (b) If veteran, name was None 3. (c) Social Security No. None

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 1872 years

7. Birth date of deceased Aug. 10th 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 1 3 _____ hr. _____ min.

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

10. Usual occupation None listed

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Rev. L. G. Rogers

(b) Address 2625 Spruce

17. (a) Burial (b) Date thereof Sept 16, 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director H. A. Blackman & Co.

(b) Address 13 E. mo.

19. (a) Sept. 16, 1940 (b) M. M. Crovel
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limit, write "RURAL")
(d) Street No. 1005 Locust Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 13th
year 1940 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from July 26th, 1940 to Sept. 13th 1940; that I last saw him alive on September 13th, 1940, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Diffuse abdominal carcinomatosis,
origin undetermined.

Due to Primary aet. unknown
Due to _____

Other conditions 33
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy See above

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)
Means of injury 1
23. Signature Dr. R. Thon (M. D. or other)
Address Med. Dir. K. G. Gen. Hosp. Date signed 9-14-40

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

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

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 *H. D. Blackman*

Licensed Embalmer No. *3639*

P. O. Address *F. C. W.*

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.