

Registration District No. **391**

Primary Registration District No. **4230**

Registrar's No. **56**

1. PLACE OF DEATH:

(a) County **IRON**
 (b) City or town **IRONTON**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
RESIDENCE
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **2**
(Specify whether years, months or days)
 In this community **—**
years, months or days

3. (a) PRINT FULL NAME **YETTA MEARL AKE**

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

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **ELI P. AKE** 6. (c) Age of husband or wife if alive **34** years

7. Birth date of deceased **NOVEMBER 30 1907**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	32	9	2	hr. — min. —

9. Birthplace **WEST LOUISVILLE KENTUCKY**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business **—**

12. Name **JOSEPH BUMPUS**

13. Birthplace **RURAL KENTUCKY**
(City, town, or county) (State or foreign country)

14. Maiden name **NANCY SHIVELY**

15. Birthplace **WESTVILLE KENTUCKY**
(City, town, or county) (State or foreign country)

16. (a) Informant **ELI P. AKE**

(b) Address **ARCADIA, MISSOURI**

17. (a) **BURIAL** (b) Date thereof **SEPT. 4-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MASONIC CEMETERY**

18. (a) Signature of funeral director **Geo. P. Luchel**

(b) Address **Sanitarium**

19. (a) **9-5-40** (b) **Julia A. Hunter**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **IRON**
 (c) City or town **IRONTON**
(If outside city or town limits write "RURAL")
 (d) Street No. **6**
(If rural, give location)
 (e) If foreign born, how long in U. S. A? **—** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **2**
 year **40** hour **3** minute **10 P.M.**

21. I hereby certify that I attended the deceased from **6-26**
 19**40** to **9-2** 19**40**
 that I last saw **her** alive on **8-2** 19**40**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion**

Due to **—**
 Due to **Unknown**

Other conditions **Lung Abscess**
(Include pregnancy within 3 months of death)

Major findings: Of operations **—**
 Of autopsy **—**

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 time of place)
 (e) Means of injury **—**

23. Signature **George L. ...** (M. D. or other) **—**
 Address **Ironton Mo** Date signed **9-5-40**

Duration **2**
 PHYSICIAN **—**
 Underline the cause to which death should be charged statistically.

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

9412

Coronary Occasion
Henry Johnson

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. 9/2/40
working under my personal supervision.

Signed Geo P Leuchel

Licensed Embalmer No. 3475

P. O. Address Clinton Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **32179**
Registrar's No. **00**

Registration District No. **391**

Primary Registration District No. **4230**

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

1. PLACE OF DEATH:

(a) County **Douglas**
(b) City or town **Fronton**
(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 _____
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Zetta merl ase**

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 **32** Months **9** Days **2** If less than one day _____ 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (c) Signature of funeral director _____

(b) Address _____

19. (a) _____ (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 **9** day **2**
year **1990** 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.

Immediate cause of death **Coronary occlusion**
9412

Due to **Lung abscess**

Other conditions **Shingles Infection**
(Include pregnancy within 3 months of death) **N.M.D.**

Major findings: Of operations _____

Of autopsy _____

Duration
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) _____ (Means of injury)

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

Address _____ Date signed _____

SUPPLEMENTAL

