No. 2
10-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 6 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

20883
State File No.

Registration District No. 158 — Primary Registration District No. 4092 — Registrar's No. 99

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

1900

1. PLACE OF DEATH:
(a) County Cass
(b) City or town Raymore (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none! (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 4 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Cass 19 0 0
(c) City or town Raymore (If outside city or town limits write "RURAL")
(d) Street No. None (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Mattie Ann Akers
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Fe 1
5. Color or race Wh
6. (a) Single, widowed, married, divorced W.
6. (b) Name of husband or wife James L. Akers
6. (c) Age of husband or wife if alive Deceased years
7. Birth date of deceased Sept (Month) 11 (Day) 1868 (Year)

8. AGE: Years 73 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Jackson Co (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name John Kincaid
13. Birthplace Ohio! (City, town, or county) (State or foreign country)
14. Maiden name Sarah Jane
15. Birthplace Ohio! (City, town, or county) (State or foreign country)
16. (a) Informant Jessie Akers
(b) Address Harrisonville
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 30 42 (Month) (Day) (Year)
(c) Place: burial or cremation Wills Cemetery Raymore
18. (a) Signature of funeral director Atkinson Bros
(b) Address Raymore Mo
19. (a) June 29/42 (Date received by local registrar) (b) Margaret Wolle (Registrar's signature)

1041 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26 year 1942 hour near 10 minute 00 P.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.

Cause	Duration
Immediate cause of death Hemorrhage of Lungs	
Found dead in bed	
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 Frank E. Boyles (M. D. or other)
Address acting Coroner Harrisonville, Mo Date signed 6-29-42

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 Floyd Atkinson

Licensed Embalmer No. 3920

P. O. Address Harrisonville

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
DM—8-21-41
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State File No. 20883

Registration District No. 158 Primary Registration District No. 4092 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Cass
(b) City or town Raymore
(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 years, months or days)

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mattie A Aker
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 W

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

7. Birth date of deceased Sept (Month) 11 (Day) 1868 (Year)

8. AGE: Years 73 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
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) (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 26
year 1942 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.

	Duration
Immediate cause of death	
(a) Hemorrhage of lungs	
Due to (b) Tuberculosis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

SUPPLEMENTARY 3 Pl

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) Manner of injury

23. Signature J A Scott (M. D. or other)
Address Harrisonville Mo. Date signed 8/9/42