No. 2
—5-42
5-17-39
X32

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1869

State File No.

FILED FEB 5 1943

Registration District No. 59

Primary Registration District No. 4097

Registrar's No. 16

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

1. PLACE OF DEATH:
(a) County Cass
(b) City or town Harrisonville (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: West Pearl 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 1 hour years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Cass 19
(c) City or town Rural 0 (If outside city or town limits, write "RURAL")
(d) Street No 1/4 Mi So. Garden City Mo. (If rural, give location) 0
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Jerry Albert Akins
3. (b) If veteran name war
3. (c) Social Security No.
4. Sex Male 0
5. Color or race Wh.
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 16 (Day) 1942 (Year)

8. AGE: Years — Months 8 Days 3 If less than one day hr. min.

9. Birthplace Garden City (City, town, or county) Mo. (State or foreign country) 0
10. Usual occupation
11. Industry or business —
FATHER
12. Name Jerry Dee Akins
13. Birthplace Cedar Co. (City, town, or county) Mo. (State or foreign country) 0
MOTHER
14. Maiden name Doris Albert Maynard
15. Birthplace Garden City (City, town, or county) Mo (State or foreign country) 0
16. (a) Informant Doris A. Akins
(b) Address Garden City Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23/43 (Month) (Day) (Year)
(c) Place: burial or cremation Garden City Cem
18. (a) Signature of funeral director Atkinson Bros
(b) Address Harrisonville Mo
19. (a) Jan. 23, 1943 (Date received local registrar) (b) Margaret Volle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 18 year 1943 hour 5 minute 35 A.M.
21. I hereby certify that I attended the deceased from 1-17 1943 to 1-19 1943 that I last saw him alive on 1-19 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	2 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy no 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 U. S. J. McCormick & Co. (M.D. or other)
Address Garden City Date signed 1-19-43

1047

(Licensed Embalmer's Statement on Reverse Side)

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 me

..., Registered Apprentice No.....

working under my personal supervision.

Signed Hoyd Atkinson

Licensed Embalmer No. 3920

P. O. Address Farmersville Mo.

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, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1869

Registration District No. 59 Primary Registration District No. Registrar's No. 16

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County: Cass

(b) City or town: Harrisonville (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 years, months or days)

In this community

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: Jerry Albert Akins

3. (b) If veteran, name war:

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: S

6. (b) Name of husband or wife

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

7. Birth date of deceased: May (Month) 16 (Day) 1868 (Year)

8. AGE: Years | Months: 8 | Days | If less than one day min.

9. Birthplace: (City, town, or county) MO (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 Jan. Day year 1943 hour minute M.

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

Immediate cause of death: Pneumonia Duration 2 days.

Bronchopneumonia

Due to: Lobar Pneumonia

Due to: Pneumococci of the Diplococcus mucosus Strain.

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations: 10

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (c) Means of injury

23. Signature: J. E. McDonald M.D. Type or print

Address: Raiden City Date signed 1/14/43