Dr. Calhoway & Smith

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 15 19[illegible]
Registration District No. [illegible]28

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31614

Primary Registration District No. 2000

Registrar's No. 758

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

9 2 6

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution:
Spfd. Bapst. Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 139

(c) City or town Springfield 6
(If outside city or town limits, write "RURAL")

(d) Street No. 1424 St. Louis
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Eva Akins

3. (b) If veteran, name war no

3. (c) Social Security No. 491-05-4497

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife None

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

7. Birth date of deceased Nov. (Month) 9 (Day) 1890 (Year)

8. AGE: Years 52 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Humansville (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Telephone Operator

11. Industry or business

FATHER
12. Name John R. Akins
13. Birthplace Humansville, (City, town, or county) Missouri (State or foreign country) 0

MOTHER
14. Maiden name Sarah C. Keirsey
15. Birthplace Polk County (City, town, or county) Missouri (State or foreign country) 0

16. (a) Informant Mrs. J.R. Shroter
(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13, 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Eastlawn

18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) 9-13-43 (Date received local registrar) (b) E W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12
year 1943 hour 4 minute 50 a. M.

21. I hereby certify that I attended the deceased from Aug 28, 1943 to Sept 12 1943
that I last saw her alive on 9/11/43 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of ovaries	about 1yr
Due to 49a	
Due to	
Other conditions Ascites - Abd - (Include pregnancy within 3 months of death)	2mo

Major findings: Of operations Ca. of ovaries.
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 Guy D Calloway (M. D. or other) MD
Address Springfield Mo Date signed 9/13/43

(Licensed Embalmer's Statement on Reverse Side)

914

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 L. Dolan Gorman

Licensed Embalmer No. 3177

P. O. Address Springfield Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.