

FILED MAY 8 1944

Registration District No. 280

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5963

State File No.

15505

Registrar's No. 49

1. PLACE OF DEATH:

- (a) County Platte
(b) City or town Rural - May Township
(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 69 years -
years, months or days)3. (a) PRINT
FULL NAMEHenry Aikman

3. (b) If veteran,
-
- name war _____

3. (c) Social Security
-
- No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Widowed
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased
- Feb - 28 - 1855
-
- (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
89 1 18 _____ hr. _____ min.

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

10. Usual occupation
- Farmer

11. Industry or business

12. Name
- Henry Aikman

13. Birthplace
- 9
-
- (City, town, or county) (State or foreign country)

14. Maiden name
- 9

15. Birthplace
- 9
-
- (City, town, or county) (State or foreign country)

16. (a) Informant
- Henry Aikman

- (b) Address
- R.R. #3, Parkville, Mo.

17. (a)
- Burial
- (b) Date thereof
- April 18-44
-
- (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation
- Barry Cemetery

18. (a) Signature of funeral director
- W. A. Johnson

- (b) Address
- Parkville

19. (a)
- 4-21-44
- (b)
- Mrs. Clay Hyllee
-
- (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Platte
(c) City or town Rural - May Township
(If outside city or town limits, write "RURAL")

- (d) Street No.
- R.R. #3, Parkville, Mo.
-
- (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- April
- day
- 16
-
- year
- 1944
- hour
- 4
- minute
- 25
- A.M.

21. I hereby certify that I attended the deceased from December 25, 1943 to April 16, 1944
that I last saw him alive on April 15, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Circulatory failureDue to Cardiac Decompensation

Due to _____

Other conditions _____
(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 type of place)
(e) Means of injury _____23. Signature W. A. Johnson (M. D. or other) Do.Address Parkville, Mo. Date signed 4-16-44

RECEIVED

District Health Officer No.

District File Number

Date Filed

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 *J. S. Walton*

Licensed Embalmer No. *2744*

P. O. Address *Kansas City, 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.