DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 18197

FILED JUN 8 1944

Registration District No. 8 1944 Primary Registration District No. 5568 Registrar's No. 121

**1. PLACE OF DEATH:**

(a) County Jackson

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

(c) Name of hospital or institution: Home (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community 16 Years years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson

(c) City or town Rural route No. 1 (If outside city or town limits, write "RURAL")

(d) Street No. Silver Lane Road (If rural, give location)

(e) Citizen of foreign country? --- (Yes or No)

If yes, name country

**3. (a) PRINT FULL NAME** Jacob Anderson Akers,

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Lizzie E Akers,

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased September (Month) 12 (Day) 1869 (Year)

**8. AGE:** Years 74 Months 7 Days 13 If less than one day 13 hr. 10 min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Jacob Seek,
13. Birthplace (City, town, or county) Kencucky, (State or foreign country)

MOTHER
14. Maiden name Robinson,
15. Birthplace (City, town, or county) Tennesee, (State or foreign country)

16. (a) Informant Mrs Lizzie E. Akers

(b) Address Silver Lane Road Rt #1

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

(c) Place: burial or cremation Mount Morriah

18. (a) Signature of funeral director Att Mitchell

(b) Address Independence, Missouri

19. (a) MAY 17-44 (Date received local registrar) (b) James W Ross (Registrar's signature)

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month May day 13 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from Jan 1, 1944, to April 15, 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 Bronchial Pneumonia — Duration 3 days

Carcinoma Bronchus — 1 year

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

47C

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 Fred W Kirk MD (M. D. or other)

Address Fairmount Date signed 5/16/44

1163

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK

## 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. [redacted]

working under my personal supervision.

Signed Henry G. Mitchell

Licensed Embalmer No. 3925

P. O. Address Andy. 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.**

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 147 Primary Registration District No. 5568 Registrar's No. 121

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Rural Blue Twp.
(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 Jocab A. Aker
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 M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept. (Month) 12 (Day) 1869 (Year)

8. AGE: Years 74 Months 7 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
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) James W. Ross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 13 year 1948 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

| | Duration |
|---|---|
| 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

18197