V. S. No. 2
50M—5-42
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

39 26

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 22 1944

Registration District No. 1208

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21513

Primary Registration District No. 2000

Registrar's No. 479

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: Burge Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 days - 8 hrs.
(Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

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

(d) Street No. R # 1 O
(If rural, give location)

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

3. (a) PRINT FULL NAME Ben Akin

3. (b) If veteran, name war Unk.

3. (c) Social Security No. Unk.

4. Sex Male O

5. Color or race White

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

6. (b) Name of husband or wife None

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

7. Birth date of deceased July 14, 1915
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
✓ 28	10	27	hr. min.

9. Birthplace Strafford (City, town, or county) Mo. O (State or foreign country)

10. Usual occupation Farmer
Farming

11. Industry or business

MOTHER FATHER

12. Name Christopher C. Akin

13. Birthplace Strafford (City, town, or county) Mo. O (State or foreign country)

14. Maiden name Sherlin D. Wall

15. Birthplace Strafford (City, town, or county) Mo. O (State or foreign country)

16. (a) Informant Mrs. Velma Vaughan, sister

(b) Address Strafford, Mo. R # 1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-10-44 (Month) (Day) (Year)

(c) Place: burial or cremation Bassville Cem.

18. (a) Signature of funeral director J. W. Klingner & Co.

(b) Address Springfield Mo.

19. (a) 6-9-44 (Date received local registrar) (b) W. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7
year 1944 hour 4 minute 00 P M.

21. I hereby certify that I attended the deceased from April 12, 1944 to June 7, 1944
that I last saw him alive on June 7, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute Rheumatic Fever	4 Days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Chronic Endocarditis	

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? Means of injury?

23. Signature [illegible] (M. D. or other) MD

Address Springfield Mo. Date signed 6-9-44

(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.....

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

working under my personal supervision.

Signed..... Max Rhodes

Licensed Embalmer No. 4071

P. O. Address..... Perry Iowa

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.